~~268~~ 8 pgs

MONTANA LEGISLATIVE HISTORY

Chapter 628 19 93

Bill H _____ S 349 Original bill & history ✓ C

H. Committee on Workers' Comp Select		S. Committee on Labor & Employment Relations	
Hearing Date(s) Mar 10	✓ C	Hearing Date(s) Feb 16	✓ C
_____	___ C	Feb 20	✓ C
_____	___ C	_____	___ C
_____	___ C	_____	___ C
Date Out Mar 11	✓ C	Feb 22	✓ C

Did this bill originate in an interim committee? ___ Yes ___ No

Committee _____ Report _____

H. Committee on Labor & Employment Relations

Mar 16 ✓ C

	TRANSMITTED TO HOUSE		
3/01	REFERRED TO JUDICIARY		
3/01	FIRST READING		
3/17	HEARING		
3/19	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/27	2ND READING CONCURRED	91	1
3/30	3RD READING CONCURRED	93	6
	RETURNED TO SENATE WITH AMENDMENTS		
4/02	2ND READING AMENDMENTS CONCURRED	47	0
4/03	3RD READING AMENDMENTS CONCURRED	47	0
4/07	SIGNED BY PRESIDENT		
4/07	SIGNED BY SPEAKER		
4/13	TRANSMITTED TO GOVERNOR		
4/16	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 347		
	EFFECTIVE DATE: 04/16/93		

SB 345 INTRODUCED BY BIANCHI

ALLOW ATTORNEY FEES AND COSTS TO PLAINTIFF IN PROPERTY DAMAGE CLAIM

2/09	INTRODUCED		
2/09	REFERRED TO JUDICIARY		
2/09	FIRST READING		
2/20	HEARING		
2/22	TABLED IN COMMITTEE		

SB 346 INTRODUCED BY YELLOWTAIL, ET AL.

ALLOW CHANGE OF PREVIOUSLY APPROPRIATED WATER TO AND FROM INSTREAM USES

2/09	INTRODUCED		
2/09	REFERRED TO JUDICIARY		
2/09	FIRST READING		
2/09	FISCAL NOTE REQUESTED		
2/10	REREFERRED TO NATURAL RESOURCES		
2/12	HEARING		
2/15	FISCAL NOTE RECEIVED		
2/16	FISCAL NOTE PRINTED		
2/16	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/20	2ND READING PASSED	30	20
2/22	3RD READING PASSED	29	19
	TRANSMITTED TO HOUSE		
2/23	REFERRED TO NATURAL RESOURCES		
2/23	FIRST READING		
3/24	HEARING		
3/26	TABLED IN COMMITTEE		
4/19	MOTION FAILED TO TAKE FROM COMMITTEE AND PLACE ON 2ND READING	45	55

SB 347 INTRODUCED BY HARP, ET AL.

GENERALLY REVISE WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT

BY REQUEST OF WORKERS' COMPENSATION STATE FUND

2/09	INTRODUCED		
2/09	REFERRED TO LABOR & EMPLOYMENT RELATIONS		
2/09	FIRST READING		
2/09	FISCAL NOTE REQUESTED		
2/13	FISCAL NOTE RECEIVED		

2/15	FISCAL NOTE RECEIVED		
2/16	FISCAL NOTE PRINTED		
2/16	HEARING		
2/22	COMMITTEE REPORT—BILL PASSED AS AMENDED		
2/23	2ND READING PASSED	49	0
2/24	3RD READING PASSED	48	0
	TRANSMITTED TO HOUSE		
2/24	REFERRED TO WORKERS' COMP SELECT COMMITTEE		
2/24	FIRST READING		
3/08	REVISED FISCAL NOTE REQUESTED		
3/10	HEARING		
3/11	COMMITTEE REPORT—BILL CONCURRED AS AMENDED AND REREFERRED TO LABOR & EMPLOYMENT RELATIONS		
3/13	FISCAL NOTE RECEIVED		
3/15	FISCAL NOTE PRINTED		
3/16	HEARING		
3/20	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/24	2ND READING CONCURRED	64	36
3/25	3RD READING CONCURRED	59	40
	RETURNED TO SENATE WITH AMENDMENTS		
4/05	MOTION FAILED TO NOT CONCUR WITH AMENDMENTS ON 2ND READING	18	32
4/05	2ND READING AMENDMENTS CONCURRED	35	15
4/06	3RD READING AMENDMENTS CONCURRED	37	13
4/12	SIGNED BY PRESIDENT		
4/12	SIGNED BY SPEAKER		
4/13	TRANSMITTED TO GOVERNOR		
4/16	RETURNED TO SENATE WITH GOVERNOR'S AMENDMENTS		
4/19	2ND READING GOVERNOR'S AMENDMENTS CONCURRED	36	14
4/20	3RD READING GOVERNOR'S AMENDMENTS CONCURRED	37	13
	TRANSMITTED TO HOUSE		
4/22	2ND READING GOVERNOR'S AMENDMENTS CONCURRED	68	31
4/22	3RD READING GOVERNOR'S AMENDMENTS CONCURRED	74	26
	RETURNED TO SENATE		
4/24	SIGNED BY PRESIDENT		
4/28	SIGNED BY SPEAKER		
4/28	TRANSMITTED TO GOVERNOR		
5/10	SIGNED BY GOVERNOR CHAPTER NUMBER 628 EFFECTIVE DATE: 07/01/93		

SB 348 INTRODUCED BY HALLIGAN

REVISE SPECIAL EDUCATION FUND DISTRIBUTION

BY REQUEST OF SUPERINTENDENT OF PUBLIC INSTRUCTION

2/09	INTRODUCED		
2/09	REFERRED TO EDUCATION & CULTURAL RESOURCES		
2/09	FIRST READING		
2/09	FISCAL NOTE REQUESTED		
2/15	HEARING		
2/19	COMMITTEE REPORT—BILL PASSED		
2/20	2ND READING PASSED	49	1
2/22	3RD READING PASSED	48	0

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE
BY REQUEST OF THE STATE FUND

IN THE SENATE

FEBRUARY 9, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
	FIRST READING.
FEBRUARY 11, 1993	ADDITIONAL SPONSORS ADDED.
FEBRUARY 13, 1993	ADDITIONAL SPONSOR ADDED.
FEBRUARY 22, 1993	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 23, 1993	PRINTING REPORT.
	SECOND READING, DO PASS.
	ENGROSSING REPORT.
FEBRUARY 24, 1993	THIRD READING, PASSED. AYES, 48; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 1, 1993	INTRODUCED AND REFERRED TO SELECT COMMITTEE ON WORKERS' COMPENSATION.
	FIRST READING.
MARCH 11, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
	ON MOTION, REREFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
MARCH 20, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT

ADOPTED.

MARCH 24, 1993 — SECOND READING, CONCURRED IN.

MARCH 25, 1993 — THIRD READING, CONCURRED IN. AYES, 59; NOES, 40.

RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

MARCH 27, 1993 — ON MOTION, CONSIDERATION PASSED UNTIL THE 76TH LEGISLATIVE DAY.

APRIL 5, 1993 — SECOND READING, AMENDMENTS NOT CONCURRED IN.

PREVIOUS ACTION RECONSIDERED.

SECOND READING, AMENDMENTS CONCURRED IN.

APRIL 6, 1993 — THIRD READING, AMENDMENTS CONCURRED IN.

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

APRIL 12, 1993 — SIGNED BY PRESIDENT.

IN THE HOUSE

APRIL 12, 1993 — SIGNED BY SPEAKER.

IN THE SENATE

APRIL 13, 1993 — DELIVERED TO GOVERNOR.

APRIL 16, 1993 — RETURNED FROM GOVERNOR WITH RECOMMENDED AMENDMENTS.

APRIL 19, 1993 — SECOND READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

APRIL 20, 1993 — THIRD READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

IN THE HOUSE

APRIL 22, 1993 — SECOND READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

THIRD READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

RETURNED TO SENATE.

IN THE SENATE

APRIL 22, 1993

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

Senate BILL NO. 347

INTRODUCED BY HARP, Chas Wilson, Kennedy, Lynch, Cox, Arlestad, Christiaens, Buzzas, Keating, Blaylock, Swysgood, Nathe, Boharski, Hagedorn, Van Valkenburg, Bob Brown, Halligan, Tester, Toole, Driscoll, Carlson, Rasmussen, Grimes, Holland, Mercer, Wagner, Bergsagel, Lewis, Cladouhos, Thomas Nelson

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; REVISING PROVISIONS REGARDING IMPAIRMENT EVALUATIONS; REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, 39-71-711, AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, ~~and all policies insuring the payment of compensation under the Workers' Compensation Act~~ shall must provide that the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of ~~his~~ the person's practice. Whenever ~~such~~ the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1)~~; nor shall this~~. This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 2. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the

Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for

support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(7) "Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is

located or a board-certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.

~~(7)~~(8) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9) "Department" means the department of labor and industry.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when

further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer ~~shall~~ has not ~~have~~ operated a sufficient or any length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~(18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~(19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(17) The--term--"physician"--includes--"surgeon"--and--in either-case-means-one-authorized--by--law--to--practice--his profession-in-this-state.~~

~~(18)~~(20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment, for conditions resulting from the injury, necessary for achieving medical stability. The term includes medical,

surgical, hospital, nursing, and ambulance services and drugs or medicine.

~~(19)~~(22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~(23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~(24) "Reasonably safe tools and appliances" are ~~such~~ tools and appliances as are adapted to and are reasonably safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration, physical conditioning, or exercise programs or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a

part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under

Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. Section 39-71-704, MCA, is amended to read:

"**39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation.** (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection (1)(d)~~ this chapter, the insurer shall furnish~~, without limitation as to length of time or dollar amount,~~ reasonable primary medical services ~~by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the department for the injuries sustained, subject to the requirements of 39-71-727~~ for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

~~(b)~~(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant to rules adopted by the department~~ only if the travel is incurred at the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

~~(d)~~(e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

(f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition; or

(ii) when necessary to monitor the status of a

prosthetic device.

(g) If the worker's treating physician believes that palliative or maintenance care that would otherwise not be compensable under subsection (1)(f) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of physicians, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) The department shall annually establish a schedule of fees for medical nonhospital services and hospital outpatient services that are available in a nonhospital setting and that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients.

The department may require insurers to submit information to be used in establishing the schedule. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section 14].

(3) ~~Beginning January 1, 1988, the~~ The department shall establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates must be based on per diem or diagnostic-related groups. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities.

(4) ~~Notwithstanding subsection (2), beginning January 1, 1988, through December 31, 1991, the maximum fees payable by insurers must be limited to the fee schedule established in January 1987. Notwithstanding subsection (3), beginning January 1, 1988, through December 31, 1991, the hospital rates payable by insurers must be limited to those set in January 1988. After December 31, 1991, the~~ The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage as defined in 39-71-116.

(5) Payment pursuant to reimbursement agreements

between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(6) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

(7) (a) After the initial visit, the worker is responsible for $10 of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease.

(b) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsection (7)(a) and (7)(b), means each time the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting."

Section 4. Section 39-71-711, MCA, is amended to read:

"**39-71-711. Impairment evaluation -- ratings.** (1) An

impairment rating:

(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;

(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and

(c) must be expressed as a percentage of the whole person.

(2) A claimant or insurer, or both, may obtain an impairment rating from ~~an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice~~ a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.~~

~~(4)~~(3) Disputes over impairment ratings are not subject to 39-71-605."

Section 5. Section 39-71-727, MCA, is amended to read:

"39-71-727. **Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the physician specifies no substitutions or~~ the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the ~~physician specified no substitutions or that the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per

product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502."

NEW SECTION. **Section 6. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 7. Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with physicians or physician groups or clinics, hospitals, pharmacies, physical therapists, suppliers of

soft and durable medical goods, and other medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers.

NEW SECTION. **Section 8. Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6], through appropriate health care professionals.

(2) The department shall develop criteria pursuant to [section 10] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers.

NEW SECTION. **Section 9. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification

requirements provided in [section 10]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 10. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required

information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards

prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees

to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 11. Compliance with medical treatment required -- termination of compensation benefits for noncompliance.** An insurer that provides 14 days' notice to the worker and the department may terminate any

compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 12. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a

means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing minimum hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 13.** **Physician self-referral prohibition.** A treating physician may not refer a claimant to a health care facility outside the physician's office practice at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated

need in the community for the facility and alternative financing is not available. The insurer is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 14.** **Medical advisory committees -- composition -- function.** (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

NEW SECTION. **Section 15.** **Codification instruction.** [Sections 6 through 14] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 6 through 14].

NEW SECTION. **Section 16.** **Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are

severable from the invalid applications.

NEW SECTION. **Section 17.** **Retroactive applicability.** Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before [the effective date of this act].

NEW SECTION. **Section 18.** **Effective date.** [This act] is effective July 1, 1993.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0347, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

An act generally revising workers' compensation law to attain better medical cost containment; revising an injured workers' freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding impairment evaluations; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees.

ASSUMPTIONS:

Department of Labor and Industry:

1. The proposed legislation increases the need for the department to do additional rulemaking. 1.00 FTE (grade 17) attorney would be required to draft and defend court challenges to the rules.
2. The proposed legislation would increase rulemaking hearings and administrative contested cases that would be heard by Department's hearings officers. 1.00 FTE (grade 16) hearings officer III would be required to conduct the additional rulemaking hearings and to conduct the additional contested cases.
3. 1.00 FTE legal secretary (grade 9) would be needed to support the additional staff requirements.
4. 1.00 FTE program officer (grade 15) to establish and work with the six medical advisory committees who develop and implement palliative care review, domiciliary care, and utilization/ treatment standards, and the exclusion of unproven and unscientific procedures, as described in 39-71-704, section 1(g), and new sections 2, 7, and 9.
5. 1.00 FTE program officer (grade 15) to work on the development of Managed Care Organization (MCO) and Preferred Provider Organization (PPO) certification, maintain the MCO and PPO processes and provide oversight to ensure compliance to administrative rules.
6. 1.00 FTE program officer (grade 15) to develop a Diagnostically Related Groups (DRG) system for the uses intended in this legislation, and update DRG standards once initially established.
7. 1.00 FTE administrative assistant (grade 10) to schedule the advisory committees, file and manage the documents processing workload.
8. 1.00 FTE workers' compensation mediator (grade 16) to conduct the increased mediation workload created by additional disputes.
9. One-time start-up costs include office equipment and PCs.
10. Per diem reimbursements would be paid to advisory committee members.

(continued)

Dave Lewis 2-13-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN HARP PRIMARY SPONSOR 2/6/93 DATE

Fiscal Note for SB0347, as introduced

SB347

ASSUMPTIONS:

State Compensation Mutual Insurance Fund:

1. 1.00 FTE medical benefits coordinator and 1.00 FTE medical claims technician would assume responsibility for cost containment measures within the State Fund.
2. FY94 start-up costs include $357,000 for computer programming. Ongoing operational expenses would be incurred for computer processing charges, postage, and other incidental costs.
3. The cost containment program would not be fully implemented until approximately January 1, 1994.
4. The State Fund would notify providers and claimants of claimants responsibility to pay deductible.
5. All computer system development would be provided by contracted services.
6. Costs incurred by the Department of Labor and Industry would be assessed to workers' compensation carriers. The State Fund's share would be assessed on the same basis as current medical regulation assessments which would allocate an estimated 65% of costs to the State Fund.

FISCAL IMPACT:

Department of Labor and Industry:

Expenditures:

Employment Relations Div. (Pg 04)	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	60.55	68.55	8.00	60.55	68.55	8.00
Personal Services	1,813,414	2,078,162	264,748	1,817,143	2,085,732	268,589
Operating Expenses	943,410	1,085,418	142,008	926,413	1,030,157	103,744
Equipment	87,020	123,020	36,000	87,020	87,020	0
Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
Total	4,472,671	4,915,427	442,756	4,600,403	4,972,736	372,333
Funding:						
General Fund	348,118	348,118	0	319,589	319,589	0
State Special Revenue	1,723,306	1,772,347	442,756	1,722,779	1,762,886	372,333
Federal Revenue	635,365	635,365	0	632,662	632,662	0
Proprietary Revenue	1,765,882	1,765,882	0	1,925,373	1,925,373	0
Total	4,472,671	4,915,427	442,756	4,600,403	4,972,736	372,333
Revenues:						
WC Assessment (02)	1,723,306	1,772,347	442,756	1,722,779	1,762,886	372,333

(continued)

FISCAL IMPACT:

State Compensation Mutual Insurance Fund:

Expenditures:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	224.50	226.50	2.00	227.50	229.50	2.00
Personal Services	6,498,681	6,557,798	59,117	6,584,924	6,644,041	59,117
Operating Expenses	3,615,187	4,059,927	444,740	3,922,172	4,118,962	196,790
Equipment	310,066	325,578	15,512	236,597	236,597	0
Benefits	166,027,953	166,027,953	0	182,948,465	182,948,465	0
Transfers	2,839,300	3,127,091	287,791	2,716,695	2,958,711	242,016
Debt Service	134,256	134,256	0	221,580	221,580	0
Total (Proprietary)	$179,425,443	$180,232,603	$807,160	$196,630,433	$197,128,356	$497,923

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
Local governments which self-insure would be assessed for the additional costs incurred by the Department of Labor but would also experience long term savings on medical benefit costs as described below.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Major savings on medical benefit costs are considered likely. Based on data supplied by the National Council on Compensation Insurance, the proposed legislation could potentially reduce medical benefit costs by 6.6% to 7.0%.

SB 347

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0347, third reading.

DESCRIPTION OF PROPOSED LEGISLATION:

An act generally revising workers' compensation law to attain better medical cost containment; revising an injured workers' freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees.

ASSUMPTIONS:

Department of Labor and Industry:

1. The proposed legislation increases the need for the department to do additional rulemaking. 1.00 FTE (grade 17) attorney would be required to draft and defend court challenges to the rules.
2. 1.00 FTE program officer (grade 15) to establish and work with the six medical advisory committees who develop and implement palliative care review, domiciliary care, and utilization/treatment standards, and the exclusion of unproven and unscientific procedures, as described in 39-71-704, section 1(g), and new sections 2, 7, and 9.
3. 1.00 FTE program officer (grade 15) to work on the development of Managed Care Organization (MCO) and Preferred Provider Organization (PPO) certification, maintain the MCO and PPO processes and provide oversight to ensure compliance to administrative rules.
4. 1.00 FTE program officer (grade 15) to develop a Diagnostically Related Groups (DRG) system for the uses intended in this legislation, and update DRG standards once initially established.
5. 1.00 FTE administrative assistant (grade 10) to schedule the advisory committees, file and manage the documents processing workload.
6. 1.00 FTE workers' compensation mediator (grade 16) to conduct the increased mediation workload created by additional disputes.
7. One-time start-up costs include office equipment, PCs, and systems development. Estimated systems development costs assume that the department can utilize the existing SRS Medicaid DRG system with a minimum of system modifications.
8. Per diem reimbursements would be paid to advisory committee members.

(continued)

Dave Lewis 3-12-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN HARP, PRIMARY SPONSOR DATE

ASSUMPTIONS:

State Compensation Mutual Insurance Fund:

1. 1.00 FTE medical benefits coordinator and 1.00 FTE medical claims technician would assume responsibility for cost containment measures within the State Fund.
2. FY94 start-up costs include $357,000 for computer programming. Ongoing operational expenses would be incurred for computer processing charges, postage, and other incidental costs.
3. The cost containment program would not be fully implemented until approximately January 1, 1994.
4. The State Fund would notify providers and claimants of claimants responsibility to pay deductible.
5. All computer system development would be provided by contracted services.
6. Costs incurred by the Department of Labor and Industry would be assessed to workers' compensation carriers. The State Fund's share would be assessed on the same basis as current medical regulation assessments which would allocate an estimated 65% of costs to the State Fund.

FISCAL IMPACT:

Department of Labor and Industry:

Expenditures:

Employment Relations Div. (Pg 04)	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	60.55	66.55	6.00	60.55	66.55	6.00
Personal Services	1,813,414	2,021,161	207,747	1,817,143	2,027,771	210,628
Operating Expenses	943,410	1,062,966	119,556	926,413	1,011,381	84,968
Equipment	87,020	114,020	27,000	87,020	87,020	0
Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
Total	4,472,671	4,826,974	354,303	4,600,403	4,895,999	295,596
Funding:						
General Fund	348,118	348,118	0	319,589	319,589	0
State Special Revenue	1,723,306	2,077,609	354,303	1,722,779	2,018,375	295,596
Federal Revenue	635,365	635,365	0	632,662	632,662	0
Proprietary Revenue	1,765,882	1,765,882	0	1,925,373	1,925,373	0
Total	4,472,671	4,826,974	354,303	4,600,403	4,895,999	295,596

Revenues:
State Special Revenue (02) 1,723,306 2,077,609 354,303 1,722,779 2,018,375 295,596

FISCAL IMPACT:

State Compensation Mutual Insurance Fund:

Expenditures:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	224.50	226.50	2.00	227.50	229.50	2.00
Personal Services	6,498,681	6,557,798	59,117	6,584,924	6,644,041	59,117
Operating Expenses	3,615,187	4,059,927	444,740	3,922,172	4,118,962	196,790
Equipment	310,066	325,578	15,512	236,597	236,597	0
Benefits	166,027,953	166,027,953	0	182,948,465	182,948,465	0
Transfers	2,839,300	3,069,597	230,297	2,716,695	2,908,832	192,137
Debt Service	134,256	134,256	0	221,580	221,580	0
Total (Proprietary)	$179,425,443	$180,175,109	$749,666	$196,630,433	$197,078,477	$448,044

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
Local governments which self-insure would be assessed for the additional costs incurred by the Department of Labor but would also experience long term savings on medical benefit costs as described below.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Major savings on medical benefit costs are considered likely. Based on data supplied by the National Council on Compensation Insurance, the proposed legislation could potentially reduce medical benefit costs by 6.6% to 7.0%.

SB 347-#

Leon Stalkup, Montana Restaurant Association, submitted an amendment to SB 274 in order to comply with Federal law(Exhibit #1). Mr. Stalkup reported SB 274 encourages service for tips to continue. He stated that under current law the employer is burdened with paying additional taxes. Mr. Stalkup stated Montana taxes do not classify tips as wages and therefore the employer should not have to pay premiums. Mr. Stalkup handed out a flyer and a speech by George McGovern to further his point(Exhibits #2 and #3).

Opponents' Testimony:
Veronica Brown, President, Hotel and Restaurant Employees Union, submitted written testimony(Exhibit #4) and handed out a fact sheet about employees who receive tips.(Exhibit #5).

Terry Dolan, representing self, Missoula, stated she is a single mother of three and a waitress. Ms. Dolman informed the Committee that when she has applied for loans or food stamps her tips have always been considered her wages and if she applied for unemployment or workers compensation she would report her tips as wages.

Barbara Downing, waitress, Billings, submitted written testimony(Exhibit #6).

Cindy Polinsky, Local 427, read a statement on behalf of Margaret Olson, a disabled restaurant employee. Ms. Olson informed the Committee her temporary total benefits are reduced because of a technicality in reporting tips. Ms. Olson urged the Committee to defeat SB 274.

Don Judge, Montana State AFL-CIO, pointed out that the Federal government requires taxes to be paid on tips and requires contributions be paid to the Unemployment Trust Account. Mr. Judge stated employers in the state would be penalized if they complied with SB 274. Mr. Judge stated that if the IRS and the Federal Unemployment Department classify tips as taxable wages then there is no reason whatsoever to believe they are not taxable wages.

Questions From Committee Members and Responses:
None

Closing by Sponsor:
Sen. Keating closed the hearing by stating SB 274 would be good for Montana's economy.

HEARING ON SB 347

Opening Statement by Sponsor:
Sen. Harp, Senate District 4, introduced SB 347 to the Committee by stating it represents the first comprehensive revision of the medical delivery system under the Workers' Compensation Act. He stated the Workers' Comp Act requires the State to cover an

injured worker for a reasonable medical expense. He added SB 347 would afford the legislature the opportunity to determine what are reasonable medical services. Sen. Harp stated SB 347 is built upon the principle of cost containment and it would provide timely and quality service for the injured. SB 347 adopts a managed care system. Sen. Harp stated SB 347 will be a protection for the injured worker by involving a third party, the Department of Labor. SB 347 would restrict travel by the insured unless requested by the insurer. Sen. Harp stated SB 347 is designed to contain costs and to ensure an injured worker is taken through a managed care system from the time he/she is injured to when he/she is returned to work.

Proponents' Testimony:
Terry Mittin, Workers' Comp Coalition, stated that the Coalition he represents was formed last fall and has about 200 members who employ about 50,000 people in Montana. Mr. Mittin stated his strong support of SB 347 and added that, if passed, SB 347 will benefit Montana's economy a great deal. Mr. Mittin highlighted sections of SB 347 he felt were crucial improvements to Montana's workers' comp system: 1) domicile care reform, 2) compliance with medical care, 3) reduction of costs for prescription drugs, 4) independent doctor and hospital/insurers contracts, 5) control of referrals for profit.

Rick Hill, Governor's Office, stated workers' compensation premiums are increasing at a rate the Montana economy cannot afford. He stated SB 347 will bring cost containment to the medical care while protecting the needs of the injured.

John Guy, President, St. Peter's Community Hospital, stated the elimination of fraud and abuse of the system and duplication of services are the right way to go. He added managed care will help contain costs. Mr. Guy stated his concerns with SB 347, specifically the proposal to pay out-patient services using a non-hospital fee schedule. Mr. Guy concluded hospitals generally support SB 347.

Bob Olsen, Montana Hospital Association, submitted written testimony(Exhibit #7).

Pat Sweeney, State Fund, stated the State Fund spent almost $37 million on medical expenses in fiscal year 1992. He stated medical expenses account for over half of the 20% rate increase the State Fund experienced at the beginning of fiscal year 1993. Mr. Sweeney stated medical cost containment is essential to managing workers' comp.

Pete Strizich, State Insurance Department, handed out statistics(Exhibit #8) and explained that they illustrate the cost to the workers' comp system of medical costs.

Bill Shaw, physician, submitted written testimony(Exhibit #9).

Rose Hughes, Executive Director, Montana Health Care Association, stated her support of SB 347.

Dr. Terry Jackson, physician, stated his support of SB 347.

Harlee Thompson, Intermountain Trust, submitted written testimony(Exhibit #9a).

Cal Winslow, Deaconess Medical Center, Billings, stated his support of SB 347.

Dr. John Diggs, Bozeman, stated his support of SB 347.

Riley Johnson, National Federation of Independent Business, stated his organization's support of SB 347.

Jacquline Lenmark, American Insurance Association, stated her organization's support of SB 347.

Chuck Hunter, Department of Labor and Industry, stated SB 347 provides the Department with significant new responsibilities and regulatory requirements. The intent is for the Department to provide input to the process.

Jerry Loendorf, Montana Medical Association, stated his organization's support of SB 347.

George Wood, Executive Secretary, Montana Self-Insurers Association, stated his support of SB 347.

Opponents' Testimony:
Don Hecht, chiropractor, stated the benefits of chiropractic practices to the health care delivery system. Mr. Hecht stated the costs in Montana for total chiropractic costs in work comp is at $1.8 million which is less than 1% of the budget. Mr. Hecht passed out a study on chiropractic treatment(Exhibit #10).

Bonnie Tippy, Montana Chiropractors Association, submitted amendments to the Committee(Exhibit #11) and stated the Association wants to be part of the solution and not part of the problem. Ms. Tippy also passed out history of House Bill 33 enacted in the 51st Legislative Session(Exhibit #12). Ms. Tippy stated she has some concern about SB 347 regarding the fact that consulting physician is defined as a medical physician only and the Bill lacks a statement of intent. Ms. Tippy urged the Committee to amend the Bill.

Mark Staples, urged the Committee to amend SB 347 and to look at and adopt the amendments submitted by the Montana Chiropractor Association.

Charles Brown, chiropractor, Billings, submitted an article which addresses self-referral by physicians(Exhibit #13) and urged the Committee to view chiropractic care as a very cost-effective

means of treatment.

Jerry Connolly, physical therapist, Billings, submitted written testimony and suggested amendments(Exhibit #14).

Russell Hill, Montana Trial Lawyer Association, submitted written testimony(Exhibit #15).

Don Judge, Montana State AFL-CIO, stated he would like to work with the Committee on amendments to SB 347. Mr. Judge said he was concerned that SB 347 would limit a worker's ability to work and receive quality treatment if injured. Mr. Judge feels the burden is on the worker to prove the effect of the injury. Mr. Judge stated there are many good aspects of SB 347 but there is an awful side to it as well.

Greg Loushin, pharmacist, Butte, submitted amendments on behalf of the Montana State Pharmaceutical Association(Exhibit #16).

Gary Lusin, physical therapist, Bozeman submitted written testimony(Exhibit #17).

Roger Tippy, Montana State Pharmaceutical Association, urged the Committee to adopt the amendments submitted by the Pharmaceutical Association.

Richard Smith, physical therapist, submitted written testimony(Exhibit #18).

Gail Wheatley, President, Montana Physical Therapy Association, urged the Committee to allow physical therapist to participate in the managed care system.

Kirk Hanson, Montana Association of Private Practice Physical Therapists, Helena, encouraged the Committee to amend SB 347 to include physical therapists.

Lorin Wright, Physical Therapy Association, Red Lodge, submitted written testimony(Exhibit #19).

Ann Lawson, physical therapist, submitted written testimony(Exhibit #20).

Mike Pardis, physical therapist, stated his support for amendments to SB 347.

Wayne Jacobsmeyer, chiropractor, Columbia Falls, urged the Committee to amend SB 347.

Questions From Committee Members and Responses:

Sen. Lynch asked Sen. Harp how the PPO would work. He asked if it would be a bidding process. Sen. Harp answered the PPO could be done independently or as a part of a managed care organization.

Sen. Lynch asked Sen. Harp why HMO's are not in SB 347. Sen. Harp replied they are not included in SB 347 because the Bill is all-inclusive. He said he would be willing to look at including them.

Sen. Lynch asked Sen. Harp if he thought chiropractic care is valid as a method of treatment. Sen. Harp replied it is a valid form of care and the cost to the state is minimal. He said the problem is the large costs incurred by the hospitals.

Sen. Blaylock asked Sen. Harp if he has examined any of the amendments. Sen. Harp replied he has worked with the chiropractors.

Sen. Blaylock asked Leon Stalkup why the chiropractors and physical therapists are opposed to SB 347. Mr. Stalkup replied they are opposed to their clients being pulled away from them to a managed care system. Mr. Stalkup said chiropractors are also unhappy about being excluded from the impairment rating process.

Sen. Lynch asked Sen. Harp what parts of SB 347 he will not compromise on. Sen. Harp responded he will not compromise on freedom of choice and willing provider.

Closing by Sponsor:
Sen. Harp closed the hearing on SB 347 by saying he speaks for employers and employees across Montana He stated he hopes the system is allowed to pass a reform measure that means something for the public.

ADJOURNMENT

Adjournment: 3:05

SEN. TOM TOWE, Chair

PATRICIA BROOKE, Secretary

TET/pmb

930216LA.SM1

ROLL CALL

SENATE COMMITTEE Labor & Employment Relations DATE 1/20/93

NAME	PRESENT	ABSENT	EXCUSED
Sen. Towe			X
Sen. Wilson	X		
Sen. Aklestad	X		
Sen. Blaylock	X		
Sen. Keating	X		
Sen. Lynch	X		
Sen. Burnett	X		

F08

Attach to each day's minutes

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. # 7
DATE 2/16/93
BILL NO. SB 347

TESTIMONY OF THE MONTANA HOSPITAL ASSOCIATION

SENATE BILL 347

WORKER'S COMPENSATION MEDICAL COST CONTAINMENT

MHA generally supports the provisions of Senate Bill 347 which call for managed care, case management and preferred provider organizations for worker's comp. Hospitals have long urged the State Fund to develop controls on the utilization of health services by injured workers.

Much of the discussion about the problems of worker's compensation deal with the overuse of expensive medical care, lack of coordination of services and concerns about the effectiveness of treatment provided to injured workers. It is not surprising that directing injured workers to seek medical treatment on their own, without any limits, results in high utilization, doctor shopping and longer periods of unemployment. Hospitals believe that careful coordination of medical services by managed care organizations or insurers will result in savings to the insurers, and improve the effectiveness of treatment.

There are some provisions of SB 347 that concern hospitals that should be called to the attention of the committee.

Section 3, page 10 This part describes the services an insurer must provide to an injured worker. North Valley Hospital in Whitefish suggests that the bill be amended to require the physician to assess the "functional capacity" of the injured worker. Physicians would be required to determine what the injured person could do, rather than focus on what the injured person is unable to do. A functional capacity assessment would help employers with "early return to work" programs.

A functional capacity assessment would also help employers comply with the Americans with Disabilities Act. The ADA requires that employers make reasonable accommodations in employing disabled workers. The bill could also link a workers willingness to participate in early return to work with receipt of benefits.

Page 12, line 17 MHA would advise the committee that SRS has similar restriction in Medicaid program which the Department of Labor should adopt. SRS relies on determinations made by the Health Care Financing Administration and the Food and Drug Administration regarding medical treatment.

MCA 39-71-704(3) MHA is concerned that this section of the law will be amended again this session. As you can see, this section of the law has been amended every session, and most special sessions, since 1986. This section of the law has worked to reduce payments to hospitals every year. Hospitals now receive, on average, only 62 cents for each dollar of care delivered to injured workers. This ratio is getting worse every year. In 1992, hospitals provided a $9 million subsidy to the state fund alone. A similar discount is provided to private insurers.

Another problem with this statute is the unfair treatment of hospitals located in Montana. Even though this bill provides no exemptions, insurers apply the payment limits only to hospitals located inside Montana. Hospitals outside Montana are paid full charges. This causes a terrible disadvantage for Montanans, and creates an incentive to refer patients outside the state.

This law also is applied to every service offered by a hospital. That means if a hospital operates a home health agency, that agency is limited by this statute. But if the agency is not operated by a hospital, no limit is applied. The same goes for any clinic, nursing home or other medical service.

Finally, legislators are never advised by insurers about the impact of this law on their rates. We all here about increasing health care costs. But you probably didn't know that the state fund actually paid hospitals less money in 1991 than in 1990. According to state fund data, hospitals were paid 73 percent of charges, or a total of $11.8 million in 1990, but only 66 percent of charges, or $11.3 million in 1991. Hospitals were paid 62 percent of charges, or $13.9 million in 1992.

Specific sections of the bill MHA wants to call your attention to include:

Page 12. line 21-22 MHA opposes adoption of fee schedule payments for outpatient hospital services. Fee schedules do not reflect the hospitals costs, differences in staffing and intensity of service. Fee schedules reflect the cost of the personal service offered by physician or other provider, and the office expense. Hospitals, unlike non-hospital providers, treat all patients regardless of their ability to pay, meet strict facility standards, are open 24 hours per day, every day, and therefore incur higher costs. HB 347 should not arbitrarily reduce payments to hospitals in this fashion.

Hospitals would also find it difficult to comply with this requirement. First, the bill only limits those services available in non-hospital settings. Does this mean available in the community, or available anywhere? How will an insurer know when a service was available or not? Services are provided through the emergency room that could be provided by the community except those providers are closed. Would these be limited? What about those circumstances where a provider in the community limits the number of worker's comp cases they see? Would the service be considered "available" then?

Page 13. line 9 MHA is concerned that the Department is charged with development

of a per diem or DRG system. MHA, along with insurers, Department staff and state fund staff, met last summer to discuss this issue. This group concluded that development of DRGs for worker's comp would not be wise. The system would be expensive to develop and administer, the problems would far outweigh the advantages of DRGs. Likewise, per diem payments are simple, but unfair to hospitals. A day of care in a hospital differs greatly depending on whether it is rehabilitation or a crushed chest. A per diem simply does not account for the differences.

MHA agreed to support the call for managed care and utilization control in return for sharing the savings with providers through improved rates. This bill takes the savings, but leaves the providers out. So much for working with the State Fund.

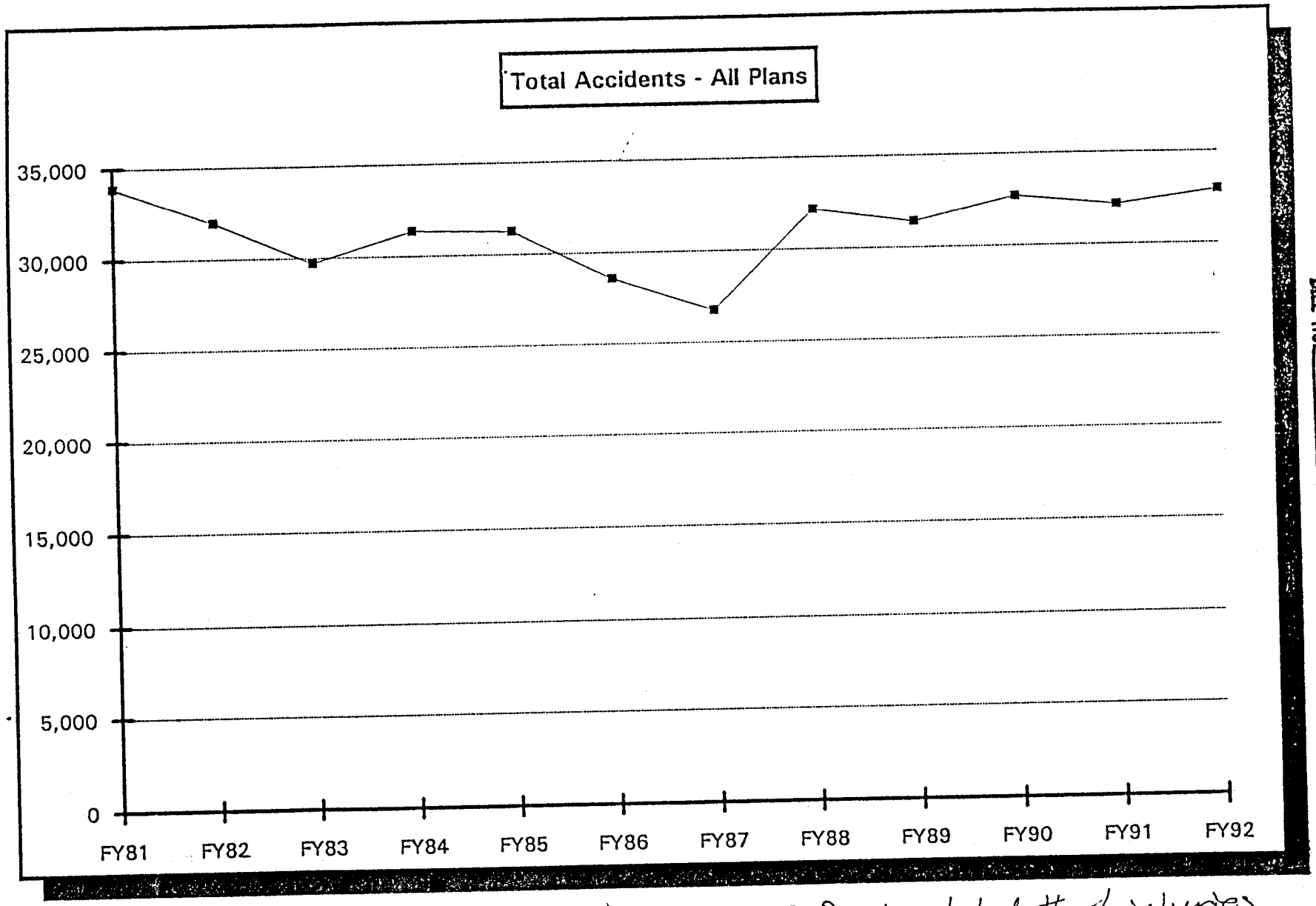
Page 14, line 22 Again, MHA objects to this language.

Sections 6 - 10 MHA supports the development of managed care arrangements in concept. We don't know if the proposed language gets this job done. It appears, however, to greatly increase the bureaucracy of getting services provided. MHA is concerned the rules and regulations required will work to reduce the number of physicians and hospitals willing to craft agreements.

Finally, MHA believes the fiscal note underestimates the cost to develop these payment mechanisms. SRS recently spent $200,000 just to study the Medicaid DRG system, and is requesting another $300,000 for the computer work to update the DRG system they already have. Similar activities will cost the State fund and the Department of Labor more than their estimates in the fiscal notes.

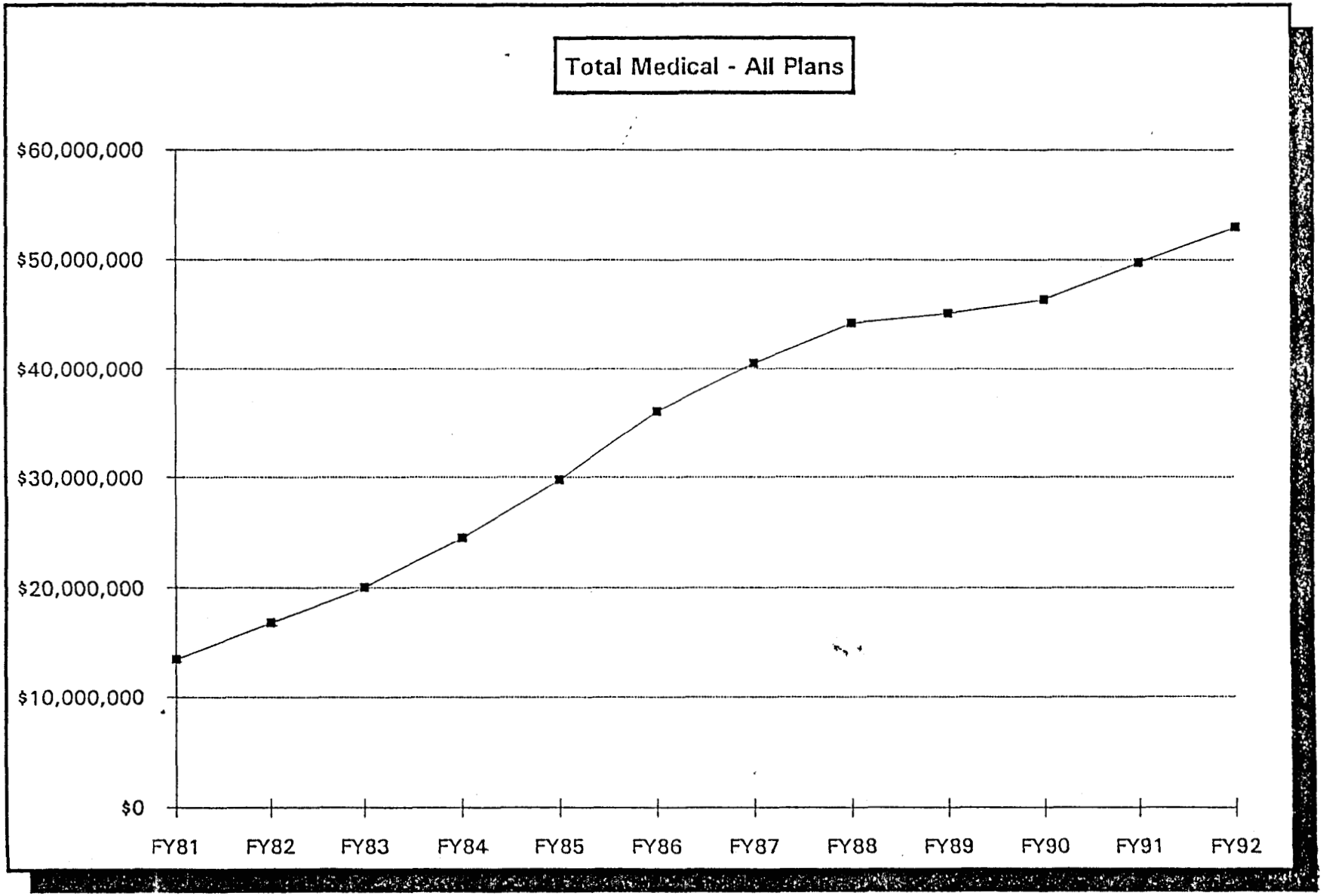
Thank you for your attention, and the opportunity to testify on this bill.

EXHIBIT 7
DATE 2-16-93
SB 347



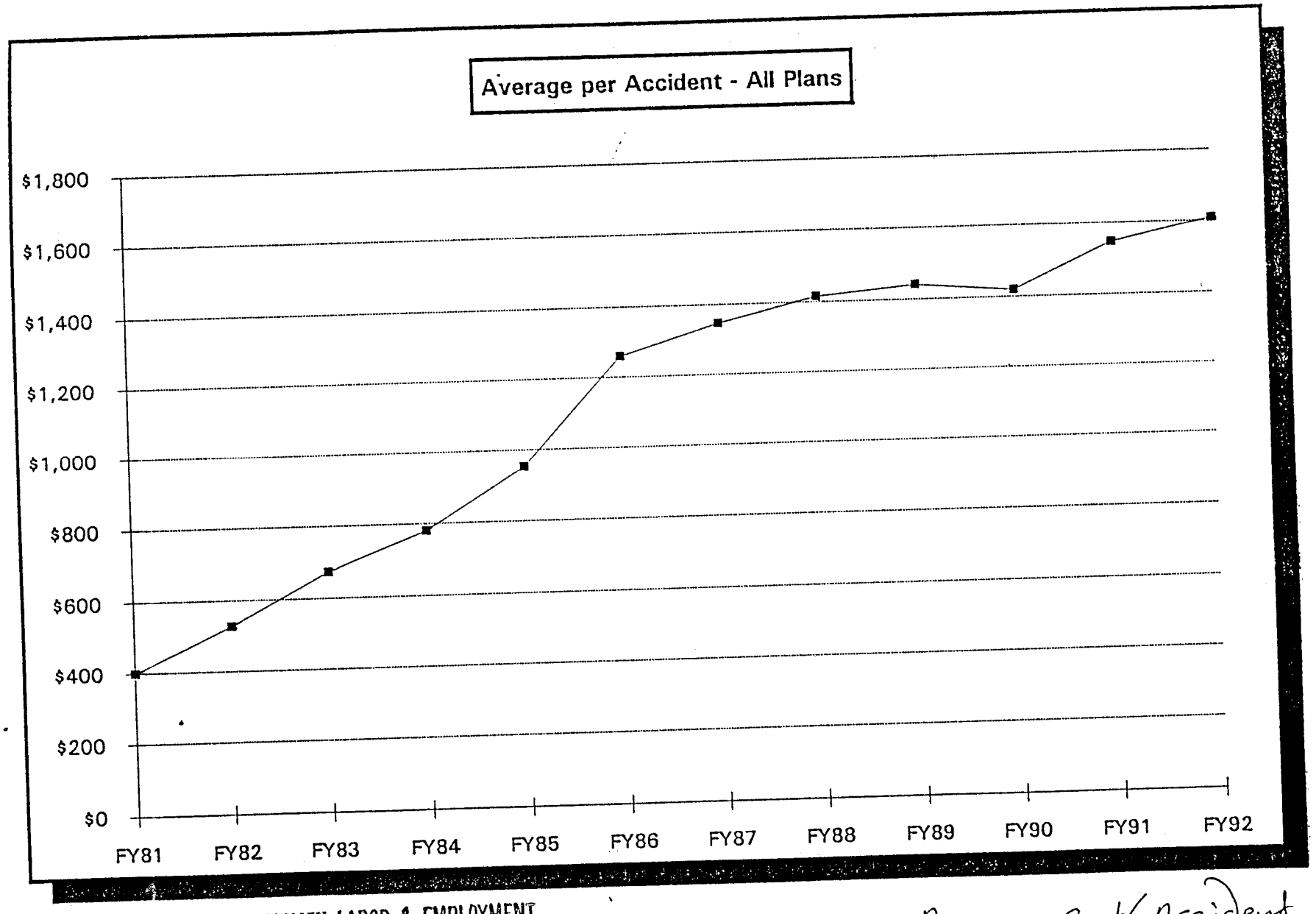
Reflects total # of injuries

EXHIBIT NO. 4
DATE 2/16/93
BILL NO SB 347



SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 8
DATE 2/16

Total med Benefits Pd



SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 8
DATE 2/16
BILL NO. SB 347

Average Cost/Accident

BILLINGS CLINIC

WRITTEN TESTIMONY
ON
WORKERS' COMPENSATION LEGISLATION
BEFORE THE
MONTANA STATE LEGISLATURE

Presented by
WILLIAM S. SHAW, M.D.
BILLINGS CLINIC
BILLINGS, MT
1-800-332-7156 (X2710)

February 16, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 9
DATE 2/16/93
BILL NO. SB 347

ALLERGY
Kathleen O. Davis, M.D.

DERMATOLOGY
Thomas P. Dormiew, M.D.
Albert O. Reynaud, M.D.
J. Michael Ventzke, M.D.

FAMILY PRACTICE
Daniel L. Gau, M.D. - West
William J. George, M.D.-Red Lodge
James F. Grotamo, M.D.-Heights
Lawrence A. Hemmer, M.D.-West
David M. Klarer, M.D.-Columbus
J. Emmett King, M.D.-West
Richard K. Klee, M.D.-Columbus
Larry W. Sonnenberg, M.D.-Red Lodge
Brian C. Weitz, M.D.-Heights
Jeffrey S. Zavala, M.D.-Red Lodge

SAME DAY CARE
Gene V. Holcen, M.D.
Ann B. Oglesby, M.D.
Andrew M. Setdon, M.D.

INTERNAL MEDICINE
F. Douglas Clark, M.D.
John J. Fina, M.D.
Steven J. Gerstner, M.D.
Paul V. Hoyer, M.D.
Lucinda M. Hruska, M.D.
Elaine S. Samuel, M.D.

CARDIOLOGY
Michael W. Brennan, M.D.
John R. Burg, M.D.
Walter C. Degnan, M.D.
David M. Gonzalez, M.D.
Herman D. Sorensen, M.D.

GASTROENTEROLOGY
John C. Fiske, M.D.
Mark C. Rumens, M.D.

HEMATOLOGY/ONCOLOGY
Warren C. Bowman, Jr., M.D.
- Wilderness and Mountain Medicine
Robert G. Santella, M.D.
Donald L. Thiele, M.D.

INFECTIOUS DISEASES
David L. Calhoun, M.D.
George H. Smith, M.D.

NEPHROLOGY
Donald L. Hicks, M.D.
James D. Knostman, M.D.

PULMONARY AND CRITICAL CARE MEDICINE
Walter R. Farmer, M.D.
Robert K. Merchant, M.D.
R. James Rollins, M.D.
Nicholas J. Wolter, M.D.

RHEUMATOLOGY
Susan C. English, M.D.
Phillip E. Griffin, Jr., M.D.

NEUROSCIENCES

NEUROLOGY, ELECTROMYOGRAPHY & ELECTROENCEPHALOGRAPHY
Patrick J. Cahill, M.D.
Mary D. Gaddy, M.D.
Dale M. Peterson, M.D.
Roger S. Williams, M.D.

NEUROLOGICAL SURGERY
Eugen J. Dolan, M.D.
Lashman W. Soriya, M.D.
Robert C. Wood, M.D.

OBSTETRICS AND GYNECOLOGY
James R. Harris, M.D.
Douglas A. Neuhoff, M.D.
Thomas C. Olson, M.D., P.C.
Mark E. Randak, M.D.

OCCUPATIONAL AND PREVENTIVE MEDICINE
William S. Shaw, M.D.

OPHTHALMOLOGY
James S. Good, M.D., P.C.
J. Thomas Priddy, M.D.
Mark P. Reynolds, O.D.

ORTHOPEDICS
Willard J. Fay, M.D.
Whitney S. Robinson, M.D. -
Roger S. Schultz, M.D.
James E. Scott, M.D., P.C.
Curtis R. Setterington, M.D.

OTOLARYNGOLOGY - HEAD AND NECK SURGERY

FACIAL, PLASTIC AND RECONSTRUCTIVE SURGERY
Stephen A. Kramer, M.D.
Sheri L. Rolf, M.D.

PEDIATRICS
Fred E. Gunville, M.D.
Allen R. Hartman, M.D.
Linda R. Johnson, M.D.
Paul H. Keiser, M.D. [illegible]
Patricia Sauer, M.D.

PHYSICAL MEDICINE & REHABILITATION
W. Michael Breland, M.D.
Gregg L. Singer, M.D.

GENERAL, THORACIC, CARDIAC AND VASCULAR SURGERY
Hexes D. Agnew, M.D.
Dennis[illegible] K. Brown, M.D.
John R. Gregory, M.D.
Paul R. Grimmes, M.D., P.C.
John W. Hedge, M.D., P.C.
Robert M. Hurst, M.D.
O. Agnar Johnson, M.D., P.C.
J. Scott Mukan, M.D.
Jeffrey L. Stone, M.D. - Red Lodge
Robert J. Wurmbrand, M.D.

UROLOGY
Lawrence W. Klee, M.D.
Richard B. Weldon, M.D.
C. Dale Vermillion, M.D.

MEDICAL DIRECTOR
[illegible]

ADMINISTRATION
Steven B. Hubel
John D. Jones
[illegible]

My name is William Shaw. I am a physician living in Billings and practicing at the Billings Clinic. I appreciate the opportunity to provide testimony to this legislature on an area of some concern and knowlege to me: the Workers' Compensation system.

My specialty is Occupational Medicine. Occupational Medicine is that specialty of medicine which studies hazards in the workplace, how conditions effect people in their work, prevention of injury and illness, and rehabilitation of workers back to gainful employment. For several years, I was the only physician in Montana certified in this specialty. Even now, there is only one other Occupational Medicine physician in the state, Dr. Headapohl who practices in Missoula.

My practice is such that essentially all of the ill or injured patients I see and care for are on Workers' Compensation. Accordingly, I have, from the medical viewpoint, been nearly immersed in the system since 1984. If is from this perspective that I speak with you today.

I would like to make some general observations and then offer some specific comments on the bill before you.

* In my experience, overt and intentional fraud is uncommon.

* Though indemnity costs for the system are considerably more than medical ones, the decisions that physicians are called on to make can have a major impact on both medical and indemnity costs.

* Medical management of the patient on Workers' Compensation is often different from an individual with an identical diagnosis whose condition is not work related. A variety of non medical factors must be considered as the physician seeks to care for a work related condition.

* There are a variety of medical conditions, such a low back pain, which are very poorly understood from a scientific point of view. This can make definitive decisions made in "black and white" quite difficult.

* There is often a poor correlation between objective findings, diagnosis, causation, and symptoms. Presence or absence of "objective findings" is often a poor predictor of an individual's status. These findings are important ONLY when they correlate to the remainder of the clinical presentation.

* Successful outcome from a work related condition requires the cooperative efforts of many parties including the physician, injured worker, employer, vocational rehabilitation counselor and insurer.

* There must be in place incentives for all parties involved in order to promote cooperation for the common goal: successful return to productive work. A mechanism to ensure complicance on the part of ALL parties would be useful. This would include requirements for patients to participate in appropriate treatement plans.

* The entire Workers' Compensation system is riddled with biases. That is, there are few who approach the system with an indifferent mind. And, as we all know, biases introduce a systematic error into the system resulting in a distorted outcome.

Given these observations, I would make the following comments and recommendations:

As I think about the Worker's Compensation system, I believe that the key lies in where constraints on services are placed. This recognizes that the system cannot provide all services for all workers. Simplistically, this means that controls must be placed either on a worker's access into the system, or limitations must be placed on the services rendered to all workers who have gained access to the system.

I would approach this dilemma using the following premises:

1. Access to medical care should be relatively easy.

2. Indemnity payments and services should be reserved for those who are truly injured as a result of their job.

3. Disability settlements should be consistent and relevant to the loss incurred and provided to people who are clearly and truly injured.

Indemnity Coverage (IC) would be provided to a select group who meet certain criteria:

1. The worker's medical problem clearly arises out of an incident, injury, exposure or event (either singular or over an extended period of time) which is clearly and rationally definable (Causation), is scientifically based, and is probably (more likely than not) related to the event.

2. The causative event must provide for a mechanism of injury commensurate with the pathology noted.

3. The causative incident must have some relation to the nature of the work performed and not some normal event which could have just as reasonably occurred off the job (e.g. sneeze, pick up paper from ground, etc.).

4. Subsequent covered diagnoses remote from the initial site of pathology must, on a more likely than not basis, have a clear and medically recognized correlation to the initial problem or be a recognized complication to the treatment required (e.g., vocal cord paralysis following Cloward procedure qualifies, but migratory pains from "walking funny" does not).

Apportionment should be applied to all IC claims. Apportionment would not be calculated by exact percentage but semi quantitatively instead. For example:

EXHIBIT 9
DATE 2-16-93
SB 347

Approximate Percentage	Category	% Indemnity Paid
< 50%	Possible contributor	40%
51% - 70%	Probable contributor	66%
71% - 90%	Predominant Contributor	85%
>90%	Sole Contributor	100%

PPD settlements should be based on Disability. The law must recognize that disability is not synonymous with an impairment rating. It should be specifically noted that disability can be either greater OR less than an impairment rating. The model of the 1991 law for PPD may be an appropriate model.

Return to work guidelines should be consistent with the Americans with Disability Act (ADA). This will place the state law in concord with federal statute covering individuals with disabilities. By definition, any worker who received a PPD settlement would qualify under ADA. Under ADA, an individual qualifies for protection under the law if they are PERCEIVED to have a disability.

Under ADA, employability must be based on the functional ability of an individual to perform the essential functions of a job, and not a worker's symptoms or diagnosis. If clearly definable risk is present, it is relevant only if there is a direct threat to self or others. Once again, direct threat is defined by ADA. The following exact wording from the Technical Assistance Manual is instructive.

"In order to meet the very specific and stringent requirements to establish that direct threat exists, it must be shown that there is:

> "A significant risk of substantial harm;
>
> "The specific risk must be identified;
>
> "It must be a current risk, not one this is speculative or remote;
>
> "The assessment of risk must be based on objective medical or other factual evidence regarding a particular individual and;
>
> "Even if a genuine significant risk of substantial harm exists, the employer must consider whether the risk can be eliminated or reduced below the level of a "direct threat" by reasonable accommodation."

Return to work should require from both employer and employee the same reasonable accommodation provisions outlined in ADA. It is important to understand that it is the obligation of the employee to ask for, and the employer to explore with that employee what accommodations might be possible in order for this worker to perform those essential job functions.

ADA also provides that best medical information available should be criteria for decision making. Given this, medical disagreements regarding diagnosis, prognosis, impairment, functional capacity, and appropriate accommodations should be settled by medical systems and not legal ones. For example, the treating physician may not be the best source of medical information.

Obviously, incentives designed to promote safety and prevention of injury are highly appropriate. As well, incentives to return workers who may be limited in some way is critical. The present mentality of many employers is one of "you have to be 100% or don't come back." This attitude may be based in perceived operational needs or liability risks. In either case it is clearly counterproductive. Why pay a worker to sit home and nurture frustration and disability. It is a rare business which cannot find, with a bit of thought and creativity, some productive activity at least temporarily for an injured worker. Furthermore, the liability risks are much higher for prolonged disability by keeping workers away from work than by returning them to the workplace.

I certainly concur with the concept of managing these cases in an organized and efficient manner. However, "managed care" is not a panacea. Several years ago, the SCIF contracted with an organization, HCX, to do just that without the desired results. To be effective, management of care must entail an efficient "shepherding" of individuals through the complexities of the system. An escort has a chance of helping; an overseer trained in the Simon Lagree School of Management Techniques will be counterproductive.

I have several specific comments about the Bill at hearing today.

As noted earlier, it is exceedingly difficult for me as a physician to differentiate between "Primary" and "Secondary" treatements. Defining Maximum Medical Improvement (MMI) as occurring when primary medical treatment has done all that it can might reasonably lead me to conclude that MMI has been reached when the surgical scar has healed and the stitches removed.

Physician Assistants should be able to practice in accordance with their legally authorized treatment plans. The present wording seems to authorize PA-Cs caring for Workers' Compensation patients only in remote settings, where their supervising MDs are not on site.

If injured workers are to be excluded from coverage under Workers' Compensation, as outlined in various places in HB 361 (e.g. injury not the major contributing cause, subsequent nonwork-related, etc.), provisions for coverage under 3rd party carrier must be made. Otherwise, preexisting condition exclusions will leave injured individuals with no medical coverage at all.

Finally, I believe that the unique nature of the Workers' Compensation patient makes for a feeling among many medical providers that some form of managed care in the Workers' Compensation arena is appropriate.

The special challenges including complex questions of causality, duration of disability, extent of disability, and functional capacity are routinely addressed to the treating physician. Discomfort in responding to these necessary questions has led significant numbers of providers to avoid caring for these patients. At other times, patients have sometimes been treated by clinicians for longer than may be appropriate or with modalities which may have limited efficacy.

The managed care model allows for the greater likelihood of optimum care provided in a timely fashion with a minimum of duplicated services. Judicious selection of consultants and specialized often

costly testing can be accomplished in a managed care setting. Consistency in assessment of impairment rating as well as estimation of functional capacity would also seem fairer to all parties involved in this complex system.

All in all, the basic concept of managed care seems an appropriate direction to pursue as an integral part of a broader effort to rework the system which now has many dysfunctional aspects to it.

In any system of managed care, certain critical issues must necessarily be addressed. These include:

1. Clear delineation of criteria for determination of effectiveness. Distinction must be drawn between quality of care effectiveness and cost effectiveness since they are not necessarily the same. As providers, we must always take the position that quality of care takes priority over cost.

2. Standards of care are appropriate, and often useful so long as they reflect the necessary flexibility to accommodate the variability of the human condition. It is unrealistic to expect that all medical services or all possible conditions can be forcast and addressed through such standards. The role, authority, responsibility as well as the administrative and financial support of any Medical Advisory Committee must be clearly delineated.

3. The administrative requirements of developing, operating, and maintaining a managed care organization are extensive. One has only to look at the guidelines set forth in "New Section 5" of the Medical Bill covering application and certification to get a fuller understanding of how onerous these requirements might be. The costs of implementing such services are significant. It is not likely that these management costs would be offset by increased volume of patients. Efficiencies of scale are difficult to achieve when individualized attention to detail is required.

4. Financial incentives are required under New Section 5-4(b). It is important that there be incentives for both insurer AND provider. When reimbursement is provided through a tightly regulated fee-for-service schedule, (as set forth in the upcoming Labor and Industry Rules Hearing I - XVII scheduled for February 18, 1993) incentives are absent for the provider "to reduce service costs and utilization."

5. Quality assessment and peer review requires evaluation of individual providers with exclusion from participation of those deemed to be providing excessive of inappropriate treatment. Such exclusionary practices are fraught with risks and liabilities. No organization can hope to carry out such practices without some protection from legal recourse.

In summary, the concept of managed care of the Workers' Compensation patient population has much in its favor so long as the important issues of quality of care and appropriate financial incentives can be addressed.

I would be glad to respond to questions if there are any.

9
2-16-93

Homebuilders Assoc. of Billings
252-7533

S.W. Montana Home Builders Assoc.
585-8181

Great Falls Homebuilders Assoc.
452-HOME

Montana BUILDING INDUSTRY ASSOCIATION

Flathead Home Builders A
752-2522

Missoula Chapter of NAHE
273-0314

Helena Chapter of NAHB
449-7275

Exhibit #9

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

SB 347
Worker's Comp Medical Cost Containment

Recommend:
Do Pass

Mr. Chairman, Ladies & Gentlemen of the Committee:

I am Harlee Thompson, manager of Intermountain Truss, and a delegate from the Montana Building Industry Association to the Coalition for Work Comp System Improvement (CWCSI).

No one usually argues that one of the major problems in the Worker's Comp system is the lack of specific injury definition. This has left the matter to the jurisdiction of medical practitioners who tend to over treat to avoid liability; lawyers who are anxious to ask the court for an interpretation of the injury; and confused claims examiners who deal with a variety of diverse court interpretations.

The Coalition for Work Comp System Improvement believes that the creation of stricter injury definitions will not limit benefits--only provide clear instructions for all, whether they be claimants, medical providers, employers or insurers.

The definitions of injuries contained in SB 347 gained bipartisan support during the recent election and are an important step in eliminating costly vagueness in current law.

We urge a do pass committee recommendation.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 9a
DATE 2/16/93
BILL NO. SB 347

Exhibit #10

MANDATED HEALTH INSURANCE COVERAGE FOR CHIROPRACTIC TREATMENT: AN ECONOMIC ASSESSMENT, WITH IMPLICATIONS FOR THE COMMONWEALTH OF VIRGINIA

by

Leonard G. Schifrin
Chancellor Professor of Economics
The College of William and Mary
Williamsburg, Virginia

and

Clinical Professor of Preventive Medicine
Medical College of Virginia
Richmond, Virginia

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 10
DATE 2/16/93
BILL NO. SB 347

January 1992

COPYRIGHT 1992
BY LEONARD G. SCHIFRIN

MANDATED HEALTH INSURANCE COVERAGE FOR CHIROPRACTIC TREATMENT: AN ECONOMIC ASSESSMENT, WITH IMPLICATIONS FOR THE COMMONWEALTH OF VIRGINIA

EXECUTIVE SUMMARY

1. MANDATED HEALTH INSURANCE COVERAGE, AND THE INCLUSION OF CHIROPRACTIC COVERAGE, ARE THE USUAL CASE.

All states have health insurance mandates, ranging from a low of five (including both benefit and provider mandates) in Delaware, Idaho, and Vermont, to a high of 37 in Maryland. Virginia is above the 50-states average with 19, tieing for tenth place. In all, 37 states have mandated the inclusion of the services of chiropractors. Mandates exist to provide a more socially optimal package of insurance coverage than would emerge from the private decisions of individual insurers, employers, and households.

2. MANDATED CHIROPRACTIC COVERAGE HAS MINIMAL COST-INCREASING EFFECTS ON INSURANCE, AND MAY EVEN REDUCE INSURANCE COSTS.

Mandates increase insurance costs by bringing under the insurance "umbrella" health care services that otherwise would have been paid for out-of-pocket or not purchased because patients were unable or unwilling to pay their full market prices. In either case, the effect is to increase insurance costs. On the other hand, mandates that promote disease or disability prevention reduce insurance costs, and so, too, do those that provide lower cost substitutes for more costly treatment. Before the fact, mandates neither increase nor decrease the costs of insurance. Using three statistical methods, the "claims based," "actuarial," and "hedonic price" approaches, health insurance mandates as a whole have been estimated to account for 20 percent or more of health insurance outpayments, but there is little evidence, using any of these methods, that chiropractic services increase gross outpayments by more than one percent. Considering that [1] many plans included chiropractic care before it was mandated, or would have offered it later without the mandate to do so, and [2] chiropractic offers itself as a substitute for more costly treatment of lower back pain by medical physicians, surgeons, and hospitals, the actual net cost effect of the chiropractic mandate appears to be lower than one percent, perhaps approaching zero or even being cost reducing.

3. THE LOW COST IMPACT OF CHIROPRACTIC IS DUE NOT TO ITS LOW RATE OF USE, BUT TO ITS APPARENTLY OFFSETTING IMPACTS ON COSTS IN THE FACE OF HIGH RATES OF UTILIZATION. CHIROPRACTIC IS A GROWING COMPONENT OF THE HEALTH CARE SECTOR, AND IT IS WIDELY USED BY THE POPULATION.

In the past several decades, the supply of chiropractors has increased absolutely and also in relation to medical doctors and osteopaths. There are an estimated 47,500 chiropractors in the United States. In 1960, for every new chiropractic graduate there were 11 new doctors of medicine. Despite the subsequent great growth of the annual number of new M.D.s, by 1990 there were only six new medical graduates for every new chiropractor. Between 1971 and 1991, the number of

licenses issued each year to chiropractors new to the Commonwealth of Virginia increased tenfold.

Utilization rates provide different estimates of the proportion of the population under chiropractic care. Employing lower level estimates that four percent currently use chiropractic and that 7.5 percent will use it within a three to five year period, the current chiropractic patient population numbers nine to ten million persons, and will include about twice that number over the next few years. In 1977, the last year for which such data are available, $606 million was spent for chiropractic treatment. Even if we assume that chiropractic has not grown relative to other sources of care and thus expenditures for it have only kept pace with other health care costs, the current level of spending for the services of chiropractors would exceed $2 billion. Other studies indicate that chiropractic is widely recognized by non-users as well as users; that users are representative of the population as a whole, though perhaps somewhat older and more rural; that chiropractic patients view the quality of care and their relationships with chiropractors favorably; and that heavy users of chiropractic also are heavy users of physicians' services. The picture that emerges is one in which chiropractic is a widely relied on and important form of treatment, with which patients have a high level of satisfaction.

4. FORMAL STUDIES OF THE COST, EFFECTIVENESS, OR BOTH OF CHIROPRACTIC, USUALLY MEASURED AGAINST OTHER FORMS OF TREATMENT, SHOW IT TO COMPARE FAVORABLY WITH THEM.

Twenty two studies and one "inquiry," covering many years, 14 states, and two foreign countries, have examined, in total, eight different dimensions of the cost and efficacy of chiropractic treatment of low back pain. The cost measures have included total case costs, total provider payments, total worker compensation for injury-induced wage loss, and treatment frequency. The efficacy or outcome measures include the duration of work loss, period of disability, pain relief, and patient satisfaction with treatment. In 14 state studies in the period before 1980, only in one dimension in one study does chiropractic not rank more favorably than medical treatment of low back pain. In about 35 other comparisons in these 14 studies and two general surveys, the cost and effectiveness results of chiropractic treatment are superior to those of medical treatment.

In five state studies after 1980, chiropractic also fares well, though not quite so unanimously. Except for one study, in West Virginia, the earlier generalizations about chiropractic cost and efficacy are borne out: chiropractic effectiveness often surpasses that of medical care; and, although payment to chiropractors may exceed that to M.D.s, total case costs are lower when treatment is provided by chiropractors. Other studies, in New Zealand and Great Britain, provide further evidence of the valuable role of chiropractic in the provision of care for low back injuries, in comparison with other types of treatment.

5. BY EVERY TEST OF COST AND EFFECTIVENESS, THE GENERAL WEIGHT OF EVIDENCE SHOWS CHIROPRACTIC TO PROVIDE IMPORTANT THERAPEUTIC BENEFITS, AT ECONOMICAL COSTS. ADDITIONALLY, THESE BENEFITS ARE ACHIEVED WITH APPARENTLY MINIMAL, EVEN NEGLIGIBLE IMPACTS ON THE COSTS OF HEALTH INSURANCE.

6. THE CONCLUSION OF THIS ANALYSIS IS THAT CHIROPRACTIC MANDATES HELP MAKE AVAILABLE HEALTH CARE THAT IS WIDELY USED BY THE AMERICAN PUBLIC AND HAS PROVEN TO BE COST-EFFECTIVE.

The Effectiveness and Cost Efficiency of Chiropractic Care for Injured Workers

ropractic: (Greek: treatment by hand) is
the third largest primary health care profession
e western world after medicine and dentistry.
e are approximately 36,000 chiropractors
e United States.

practic has had an interesting emergence, arising as a separate profession
1890s. In that era of heroic medicine, many alternative disciplines emerged—
practic has been the strongest survivor. The profession has always presented
as a natural and conservative source of health care, offering an alternative
dication and surgery. Accordingly, it makes no use of drugs or surgery.
profession's central interest always has been the relationship between
red movement of spinal vertebrae and the nervous system, and the effect
s on health. Its principal treatment is joint adjustment or manipulation.
s supplemented by a wide range of physical therapy modalities.

Montana, chiropractors have been licensed for over 50 years, and that
sure was granted through public referendum. Educational requirements in this
include a minimum of two full academic years of college or university work
an institution acceptable to the board of regents of higher education, and
ss than four school years, of not less than 9 months each, from a college
iropractic approved by the state board. In other words, chiropractors in
ana have a minimum of six years of higher education.

practors are an integral part of our overall health care system, with an
growing number of patients who have benefitted enormously from chiro-
ic care. More and more definitive research findings show that chiropractic
is very effective, particularly in low back injury cases.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 10
DATE 2/16/93
BILL NO. SB 347

ropractic Care and Workers' Injuries

rding to the latest information from the Washington-based National Safety
ncil, occupational back injuries account for at least 20 percent of all
pational injury cases. According to the Council study, about 400,000
ling back injuries occur each year at work.

use such a large share of workers injuries are back related, chiropractors
nd do play a very large role in the treatment of injured workers. Yet, back
es are particularly problematic, because there oftentimes is no 100% cure,
ain relief and ongoing care are essential in order to get a person back to
and keep them working.

a workers' compensation system spiraling out of control, and no statistically
able answers in sight, there is now a proposal circulating that would, in
, cut off chiropractic care for injured workers. While a brief glance at such
posal may lead one to believe that such an act would cut medical costs,
ct it would really serve to do two things:
Increase direct costs for medical care to the patient . . . if someone is in
, they will go somewhere, and
Keep people from working for longer periods of time. In fact, wage claims
e a more serious drain to the workers' compensation insurance system
medical costs, and it would take many chiropractic visits indeed to cost as

The Montana Chiropractic Association is the professional organization representing over 75% of the practicing chiropractors in the state. Its membership represents chiropractors from all geographic areas of the state. The main mission of the organization is to promote and enhance the chiropractic profession through a strong ethics program, communications, education and government affairs.

For further questions, please call or write:

THE MONTANA CHIROPRACTIC ASSOCIATION
P.O. Box 6276
Helena, Montana, 59604 406-442-7275

Research Studies

RAND

The newest scientific study, published in 1992, is from the Rand Corporation, one of the nation's most prestigious centers for research in public policy, science and technology applications. The following data is from parts One and Two of a four-part study, "The Appropriateness of Spinal Manipulation for Low Back Pain":

⇨ Back pain occurs in up to 80% of adults at some point in their lives and is one of the leading causes of visits to physicians. It is appropriate for most persons with back pain to undergo an initial course of conservative therapy. Spinal manipulation is the most commonly used conservative treatment for low-back pain for which reimbursement is sought.

⇨ Even though the 9-member panel is interdisciplinary, the concensus among the panel is greater than previous panels from just one discipline have been. The spinal manipulation panel contained members from three different philosophies; chiropractic, osteopathic, and allopathic.

RAND CONCLUDES THAT SUPPORT IS CONSISTENT FOR THE USE OF SPINAL MANIPULATION AS A TREATMENT FOR PATIENTS WITH ACUTE LOW-BACK PAIN.

BRITISH MRC TRIAL

The British Medical Council's 10 year, multicentre trial compared chiropractic and hospital outpatient management of patients with acute (short term) and chronic (long term) mechanical low-back pain was published in the British Medical Journal (June 2, 1990). The conclusions reported in the Journal are as follows:

⇨ Chiropractic treatment was significantly more effective, particularly for patients with chronic (long term) and severe pain.

⇨ Results were long term; "the benefit of chiropractic treatment became more evident throughout the follow-up period of two years."

⇨ "The potential economic, resource, and policy implications of our results are extensive."

⇨ "Of those with jobs, 21% of patients given chiropractic treatment had time off work because of back pain compared with 35% of hospital patients . . . Between 1 and 2 years the frequency and duration of absence from work were less in those treated by chiropractic."

⇨ The study shows a savings in excess of 10 million pounds per year in Britain by having hospital outpatients with back pain treated by chiropractors.

Studies demonstrate the cost effectiveness of chiropractic care

Today, there is more evidence of the effectiveness of spinal manipulation—the primary treatment mode of a chiropractor—than any other treatment approach for back pain.

Numerous workers' compensation studies demonstrate a 45 to 50 percent savings in costs—both in treatment and in compensation for lost time—when chiropractic is compared to medical treatment. The most thorough studies were conducted in California (1972), Wisconsin (1978) and Florida (1988).

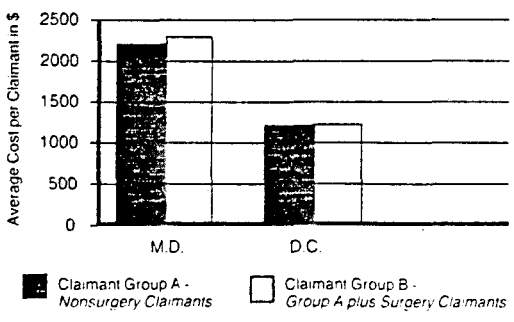
FLORIDA WORKERS COMP

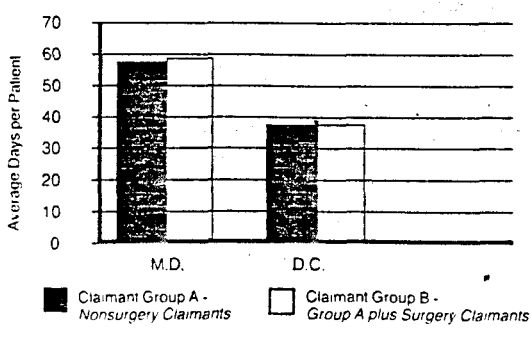
study found that:

⇨ The duration of temporary total disability for claimants was 48.7% shorter for chiropractic patients.

⇨ The average cost of chiropractic services and prescribed procedures was over 50% less than that of medical doctors.

⇨ 51.3% of the claimants treated by medical doctors were hospitalized while only 20.3% of the chiropractic patients were hospitalized.





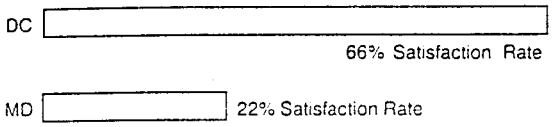
TERN
RNAL
OF
ICINE

This study concluded that:

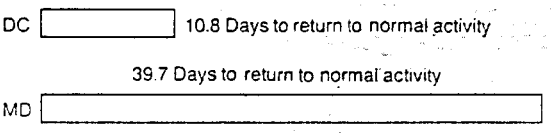
⇨ Medical doctors return patients to work in 39.7 days while chiropractors return them to work in 10.8 days.

⇨ Patients of chiropractors were three times as likely as patients of family physicians to report that they were very satisfied with the care they received for low back pain.

Comparison of Patient Satisfaction of DC and MD Care



Comparison of Patient Disability Days of DCs and MDs



MON
ALTH
OF
GINIA

This study, "Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Assessment, with Implications for the Commonwealth of Virginia," was done by Leonard G. Schifrin, Chancellor Professor of Economics, The College of William and Mary, Williamsburg, Virginia and Clinical Professor of Preventive Medicine, Medical College of Virginia, Richmond, Virginia in 1992. This study concludes that:

⇨ Mandated chiropractic coverage has minimal cost-increasing effects on insurance and may even reduce insurance costs.

⇨ The low cost impact of chiropractic is due not to its low rate of use, but to its apparently offsetting impacts on costs in the face of high rates of utilization.

⇨ Formal studies of the cost, effectiveness, or both of chiropractic usually measured against other forms of treatment, show it to compare favorably with them.

⇨ By every test of cost and effectiveness, the general weight of evidence shows chiropractic to provide important therapeutic benefits, at economical costs. These benefits are achieved with apparently minimal, even negligible impacts on the costs of health insurance.

EXHIBIT 10
DATE 2-16-93
SB 347

Conclusion

spite of all this and even more available evidence, iropractic is being singled out in Montana by a group of surers who want to severely limit or eliminate payments this type of care for injured workers. Why? It is believed the profession that this strong push by insurers represents e newest wrinkle in a 100 year old turf battle between edical doctors and chiropractors. Much of the prejudice lainst chiropractic stems from a concerted effort by e AMA to destroy the chiropractic profession, as found by federal judge and affirmed by the U.S. Supreme court the case of Wilk vs. AMA. In this case, it was ruled after 11 year legal battle that the AMA had violated the Sherman Antitrust laws by organizing a national boycott of chiropractors by medical physicians and hospitals.

Since this decision, the turf battle between chiropractors and traditional medical care providers is being conducted in a new arena, that of insurance benefits, and it is both subtle and devastating. The chiropractic profession of Montana will use the facts to push back this newest onslaught on their profession and the injured workers they serve. These facts show with no doubt that chiropractic provides injured workers with real help . . . help to relieve their symptoms, help to return them to work, help in restoring them to fully functioning individuals.

pg. 3

ne has any easy answers to the problem of back injuries; health care ns an art as well as a science in this area. Is the answer to arbitrarily cut d workers off from perhaps the best possible care they can have for their ular injury?

OLUTELY NOT; IN MANY BACK-RELATED INJURIES, NOT ONLY HIROPRACTIC CARE A MORE EFFECTIVE MEANS OF TREATMENT, BUT ALSO MORE COST EFFECTIVE THAN TRADITIONAL MEDICAL CARE.

Chiropractic Care Works

Exhibit #11

Montana Chiropractic Association
Senate Bill 347 Amendments and Discussion Points
Submitted to the Senate Labor and Employment Relations Committee
February 16, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 11
DATE 2/16/93
BILL NO. SB 347

1) ISSUE OF CHARGING FOR EVERY OFFICE VISIT

SECTION 3, Page 14, Subsection 7, line 9
Delete: $10
Insert: "10% of the cost of the visit but not to exceed $10

DISCUSSION: $10 will be a discriminatorily high percentage of the less expensive visit, i.e. chiropractor. We suggest that this language be changed to "10% but not to exceed $10 per visit.

2) CONSISTENCY OF WHO IS A PRIMARY CARE PROVIDER

SECTION 2, Page 8, subsection (21), line 1
Following: "Surgical"
Insert: "Chiropractic"

DISCUSSION: Primary medical services should include chiropractic, these changes simply make the language consistent with the fact that a chiropractor is a treating physician. Failure to include chiropractic in this section has exclusionary ramifications for elsewhere in the bill. If there is no intent to exclude chiropractic from participation in worker's comp, then this addition should pose no problem.

3) PRIMARY CARE PHYSICIAN SHOULD INCLUDE CHIROPRACTOR

SECTION 10, Page 23, line 9
Following: "general practitioner"
Insert: "chiropractor"

DISCUSSION: Primary care physician should include chiropractor as it does elsewhere in the bill. A chiropractor is listed as a treating physician and language here just needs to be clarified to make sure that

"practitioner" designations do not exclude chiropractic.

4) MANAGED CARE NOT TO "YANK" PATIENTS FROM TREATING PHYSICIANS UNLESS PROGRESS IS NOT BEING MADE

SECTION 6, PAGE 17, Subsection (3), line 23
Following: "required"
Insert: New sub subsection (e)
Insert: "Notwithstanding sub subsections a through d, authorization for a treating physician to continue to treat outside of the managed care organization shall not be unreasonably withheld if demonstrable progress towards recovery is being made as specified by the utilization guidelines in Section 3, subsection 2 and determined by the medical advisory committees."

DISCUSSION: It has been the repeatedly stated position of the persons involved in formulating managed care that it should only "kick in" when the claimant is making no progress toward work return with the initial treating physician. This position makes sense both in terms of efficiency and cost since insertion into managed care does add a new layer of decision making and may well involve heightened referral costs. This being the philosophy of managed care, this language simply gives guidelines so that claimants are not prematurely or peremptorily taken to managed care, and if the patient is making progress towards getting back to work, he should stay with the treating physician who is aiding that progress.

5) MANAGED CARE TO BE "INCLUSIVE" OF PHYSICIANS RATHER THAN "EXCLUSIVE"

SECTION 8, Page 19, line 21
Following: "workers"
Insert: New subsection (4)
Following: New subsection
Insert: "Any managed care organization shall allow participation of any treating physician who is licensed by and in good standing with their professional state board."

DISCUSSION: Again, assurances have been given by most of the

individuals in work comp reform that they acknowledge the place of chiropractic as an effective and cost effective treatment for injured workers. As such, we should make every effort to make sure they are included in managed care organizations. Without this type of language, there is every reason to believe they would not be included, because certification criteria could be adopted during rulemaking that made their participation impossible, or left it totally at the will of other treating physicians who have historically sought to discriminate against D.C.s. (Again, if the intent is not to exclude chiropractors, this suggestion should pose no problem, as it does not "gore anybody elses ox.")

6) PREFERRED PROVIDER SHOULD NOT KICK IN AT THE INITIAL VISIT, BUT RATHER AFTER MANAGED CARE BEGINS

SECTION 7, Page 19, line 8
Following: "providers"
Insert: "New subsection (1)
Following: New subsection (1)
Insert: "Nothing in this section should be read to eliminate the choice of the initial treating physician provided to the claimant in Section 6."

DISCUSSION: Overall freedom of choice has already been conceded to reform in section 1. However, freedom of choice by the claimant of the initial treating physician has been specifically preserved in section 6. If preferred provider was to apply at that point, then that choice really is not a choice, or at best a severely limited one. This amendment gives dignity to what choice remains for the claimant in section 6.

7) IMPAIRMENT EVALUATIONS

SECTION 4, Page 14-15
Delete: Entire Section

DISCUSSION: Simply stated, this is a blatant targeting of the chiropractic profession. Any effect on the overall thrust of this bill would be so minimal as to be imperceptible, while at the same time being grossly discriminatory and flying in the face of legislative intent that

originally enacted this section. And that is the best case intrepretation of this section. At worst, it could be seen to take the area of worker's comp where the most fairness should be emphasized (Given that the evaluation ultimately determines compensation) and put it into a realm of "company doctor" as it would if impairment ratings could only be given by the managed care organization. In that scenario, the worker gives up the most fundamental privilege of any medical patient...a second opinion.

8) HOW NARROW IS PREFERRED PROVIDER? DOES UNBRIDLED RULEMAKING AUTHORITY LEAVE THE DEPARTMENT DIRECTIONLESS?

Following: "organizations"
Insert: "any provider agreeing to practice under standards set in the utilization guidelines as defined in Section 2, subsection (2), and agreeing to follow other guidelines as set by the Department, shall be allowed to participate as a preferred provider."

DISCUSSION: Some may believe that this language is not necessary, as they assure us that "sole" provider is neither the intent of the Department nor the effect of this section. With the unfettered rulemaking authority given the Department, however, there are simply not the slightest assurances that these intrepretations will be those adopted. The only possible rationale for "sole provider" or, shall we say "exclusive providers", whereby a few select pharmacies, therapists, M.D.s, chiropractors, or whatever, are contracted with to the exclusion of all others, is for cost containment and volume discounts. Yet, we have been told over and over again that those "select" providers would be paid even more to "play ball." If we are really just going to choose "favorites", who will always take the insurers' side over that of the claimant, we are proceeding unconscionably in the name of reform. If not, then this type of language should serve as no threat.

9) CONTINUED TREATMENT UNDER "PALLIATIVE CARE"

DISCUSSION: This legislation recognizes in Section 3, page 12, subsection "g", that oftentimes "palliative care" keeps workers on the job. "Palliative care is defined as "treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms." The problem with

section "g" on page 12 is that it sets up a panel to review the case. We believe that from the time the insurer denies continued treatment to a full panel reviewing the case, a great deal of time can elapse during which the injured worker is in "limbo". We believe, in fact, that this provision can wind up costing more money, since the worker's condition may have degenerated to a state where they are not working. We suggest that instead of a panel, the following amendment be adopted:

SECTION 3, page 12, sub subsection (g), line 8
Following: "treatment"
Delete: Line 8-13
Insert: "If approval is not granted, then the treating physician may request approval from the department, which shall appoint a treating physician in the area of specialty from which the injured worker is being treated who shall review the treatment plan, determine its appropriateness, and make a final recommendation."

10) THE TERM "CONSULTING PHYSICIAN"

DISCUSSION: Section 2, subsection (7), page 4, defines "consulting physician', yet nowhere in the bill is this language used. If the intent of this language is to eliminate the possibility that chiropractors can review utilization of chiropractic care in worker's compensation, then it poses definite problems in the area of chiropractic care. Because M.D.s know little about chiropractic, they are simply not equipped to consult in this area. We suggest that either this definition is deleted from the bill or that it be amended to include "treating physician", not just M.D.s with hospital admitting privileges.

11) MEDICAL ADVISORY COMMITTEES

DISCUSSION: In section 14, the bill talks about "medical advisory committees" which will be made up of various providers. However, in present language the individuals who sit on these committees are left solely to the discretion of the department. We suggest the following amendment to rectify this problem:

SECTION 14, page 26, line 7
Following: "groups"
Insert: "as recommended by the state board governing these providers"

EXHIBIT 12
DATE 2-16-93
SB 347

QUESTIONS & ANSWERS
HOUSE BILL 33

1. Have chiropractors been allowed to do impairment ratings in the past?

Yes, Just a few years ago, chiropractors were able to do impairment ratings in Montana. However, the laws and rules were vague, and a few years ago worker's compensation Judge Reardon ruled testimony regarding impairment rating from a chiropractor as inadmissable. MCA took this case to court, but the ruling was upheld, based, in part, on the new workers compensation laws enacted in 1987 which specifically allowed only medical doctors to do impairment ratings.

2. Will this law start to open this process up to other types of health care providers?

No. The law specifically states "treating physician." or " Doctor of Chiropractic." Other health care providers are not physicians or Chiropractors.

3. How long have chiropractors been licensed to practice in Montana?

Over fifty years ago, chiropractors were licensed to practice through a public initiative. There are over 245 chiropractors licensed to practice in the state. The educational requirements to become a Doctor of Chiropractic are stiff in Montana. The doctor must have completed 4 years of an accredited chiropractic college (chiropractic colleges are accredited by the department of Health, Education and Welfare), and at least two years of an accredited university with an emphasis on the sciences. Doctors are also required to fulfill a minimum of 12 hours of continuing education per year.

4. Why does the law specifically require that if the treating physician is a chiropractor the first impairment evaluation must be done by a chiropractor?

Simply put, other types of physicians know very little about chiropractic, and therefore do not understand the patient's method of treatment. A fellow chiropractor understands the treatment and can make a fairer evaluation of the patient's prognosis.

5. Is there any room for a conflict of interst?

Absolutely not. The treating physician cannot do an impairment rating in any case. It must be another physician or Dr. of Chiropracitic.

6. Are there provisions for proper knowledge and experience on the part of the chiropractor doing the evaluation?

Yes! The bill provides that certification rules be enacted by the State Board of Chiropractic. All chiropractors wishing to do impairment ratings must be board certified. HB 33's statement intent provides that these rules should take into account a doctors experience in treating industrial accident cases as well as academic qualifications.

7. Do other states allow chiropractors to do impairment ratings? Yes. In a survey of surrounding states, we discovered that Minnesota, Idaho, Oregon, South Dakota, Washington and Wyoming all allow this. There have been court cases in several other states which have found that chiropractors can do ratings. Most recent is Nebraska, *Rogers vs Sparks, Citation 228, Neb. 191, 421, NW2nd Series 785 (1988).* In this case, a court found testimony from a chiropractor as inadmissable and the case was brought before the Nebraska Supreme Court, which ruled in favor of the chiropractor. Chiropractors can now do permanent impairment ratings in Nebraska. This case was decided, in part, on case law from many other states, including Arizona.

EXHIBIT 12
DATE 2-16-93
SB 347

TESTIMONY
HOUSE BILL 33
SUBMITTED BY: THE MONTANA CHIROPRACTIC ASSOCIATION
March 1, 1989

An impairment evaluation is defined as "An appraisal of the nature and extent of the patients illness or injuries as they affect his personal efficiency in one or more of the activities of daily living." An impairment rating is performed after a patient has, in the judgement of the treating physician, reached maximum rehabilitation of his injuries. Impairment ratings range from 0 to 35 or 40 percent, and are a definition of permanent disabilities due to injuries.

Why do Montana chiropractors wish to do these evaluations? The number one reason is that we are the primary treating physicians in many worker's compensation cases. A large percentage of long-term work related injuries are back related, and chiropractors have demonstrated throughout the country their ability to cost effectively treat these cases and get people back to work. Several studies of the effectiveness of chiropractic treatment in worker's compensation have been conducted throughout the country, and all show the same conclusion: chiropractic care costs less than care from medical doctors. In particular, a recent study conducted in Florida by the Foundation for Chiropractic Education and Research and the Florida Worker's Compensation Division shows that, "the duration of temporary total disability represented by the average length of the compensation period, and the indemnity payments for work days lost, were substantially less for claimants treated by chiropractors compared with those treated by medical doctors". In the group of claimants that excluded surgery patients, the period of disability was 48.7% shorter for chiropractic patients; for the claimant group that included patients who underwent surgery, the duration of disability was 51.3% shorter for chiropractic patients. The average cost of chiropractic services and prescribed procedures was significantly less than the corresponding cost for medical doctors. In both claimant groups, one which had surgery, the other not, the cost of chiropractors' services and prescribed procedures was over 50% less than that of medical doctors. The costs for medical patients without surgery was 83.8% higher than chiropractic care, and for those undergoing surgery, the cost was 95.3% higher. These statistics, representing the total treatment costs of managing a work-related back injury, more accurately reflect the cost-effectiveness of chiropractic care over standard medical care. We are providing for your information a copy of the Executive Summary of this study.

Chiropractors have been active in treating workers compensation injuries for many years in Montana. As the treating physicians, prior to the early 1980s, they were allowed to do impairment ratings for their patients. It was and still is important to patients of chiropractors that a chiropractor do that rating, simply because that person is their primary treating physician, and a chiropractor has different methods of treating than does a medical doctor.

However, the laws and rules regarding the impairment rating process were vague, and and a few years ago Worker's Compensation Judge Reardon ruled testimony regarding impairment rating from a chiropractor as inadmissable. In 1987-88, the Montana Chiropractic Association challenged the rule in court, unsuccessfully in part because of new laws enacted in 1987 regarding impairment evaluations. That is why we are here today. It is the task

of this legislature to set public policy, and we believe that it should be public policy that chiropractors are allowed to do these ratings. Chiropractors now have to send their patients to medical doctors who have no knowledge or history of the case in order to get their impairment rating. That is not in the best interest of the injured worker, and the Montana Chiropractic Association feels that a change in the law is necessary. We wish to permanently clarify that, should a treating physician be a chiropractor, then a chiropractor can do the impairment rating for their patient.

One of our first steps in studying this problem was to study how other states handle this situation. We personally contacted the surrounding states of Minnesota, Idaho, Oregon, South Dakota, Wyoming and Washington. All of these states allow chiropractors to do permanent impairment ratings, and we know of no other state in the country that does not allow it. As a matter of fact, there is quite a bit of case law on the subject, including Rogers vs Sparks, a Nebraska case. In Nebraska, a court found testimony from a chiropractor as inadmissable and the case was brought before the Nebrtaska Supreme Court, which ruled in favor of the chiropractor. Chiropractors can now do permanent impairment ratings in Nebraska. This case was decided, in part, on case law from many other states, including Arizona. Why Montana should have a policy in direct contradiction to other states is questionable, especially since it is obvious that the state funds of states allowing chiropractors to do these ratings are in no worse condition than Montana's.

Two of the arguments that have been used against Chiropractors doing these ratings are: one, that it is a purely "medical" determination, and, two, that they must rate the "whole man." We would submit to this body that "medical" is a generic term, not one that belongs exclusively to medical doctors. The Merriam-Webster Dictionary defines medical as: "of or relating to the science or practice of medicine or the treatment of disease." The term medicine is defined as: "a science or art dealing with the prevention or cure of disease." No where in these definitions does it say that these terms relate strictly to medical doctors, nor do they denote "ownership" of the terms to any specific health care provider. In addition, even workers compensation uses the term "medical" in a generic sense. Just one example is their newest form that chiropractors fill out entitled "General Medical Continued Billing."

The arguement of a chiropractor not being able to evaluate the "whole man" is also not a convincing one. Number one, chiropractors have extensive training in the health care field, and then specialize in chiropractic. We are providing for the committee copies of the graduation standards for one chiropractic college. In Montana, the licensure requirements for a chiropractor are very strict; The doctor must have completed four years at an accredited chiropractic college (chiropractic colleges are accredited by the Department of Health, Education and Welfare), and at least two years of an accredited university with an emphasis on the sciences. Montana doctors are also required to fulfill a minimum of 12 hours of technical continuing education per year. We argue that chiropractors are well able to evaluate impairments in their field of expertise. Making a statement that a chiropractor is less able to rate a back-related injury than an M.D. specializing in Neurology or Cardiology is ludicrous, but that is the way our current law reads. Any medical doctor, regardless of specialty, can rate impairments.

In addition to the background and training that chiropractors already have, our bill provides that only chiropractors who are certified by the State Board of [illegible] impairment will be allowed to rate. This is a much greater

requirement than any imposed upon medical doctors. In fact, all medical doctors have to do in order to rate any type of impairment is to be medical doctors.

The law requires that impairment evaluators use strict guidelines developed by the AMA, "Guides to Evaluation for Permanent Impairment." Chiropractors are trained and able to use these guides, and the portion of our bill that requires board certification will guarantee that any chiropractor doing evaluations is well trained to do them–a standard much stricter than any imposed upon M.D.s.

In summary, an impairment rating is a scientific evaluation, an evaluation that permanently sets percentage of disability. As primary health care providers in workers compensation cases, chiropractors should be allowed to perform this function for their patients. This bill is a fair one, and mirrors policy in every other state of the union that we are aware of, most specifically all of our surrounding states. Chiropractors have been licensed to practice in the state of Montana for over fifty years, and they obtained this licensure by public initiative. They are an ever-growing field of alternative health care, and as any of you who has utilized their services can attest, chiropractic works. That is why so many people in Montana seek chiropractic care.

We urge that this committee make this important public policy. We ask that you give HB33 a do pass recommendation.

Michael Pardis, D.C., President, MCA
Lee Hudson, D.C., Vice-President, MCA
Gary Blom, D.C., Past President, MCA
Bonnie Tippy, Executive Secretary, MCA
350 North Last Chance Gulch, Suite 312
Helena, Montana 59601
(406)442-7275

EXHIBIT 12
DATE 2-16-93
SB 347

Exhibit #12

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 12
DATE 2/16/93
BILL NO. SB 347

MONTANA HOUSE OF REPRESENTATIVES
51ST LEGISLATURE 1989
REGULAR SESSION
VOTE TABULATION

DATE: JANUARY 12, 1989
TIME: 1:46 PM

SEQ. NO: 5.0
BILL NO: HB 33
BILL SP: PAVLOVICH

ORDER OF BUSINESS 7 SECOND READING
AMD-1 SIMON D/PASS

AYES: AAFEDT, ADDY, BACHINI, BARDANOUVE, BLOTKAMP, BOHARSKI, BRADLEY, BROOKE, BROWN J, CAMPBELL, CLARK, COBB, COCCHIARELLA, CODY, COHEN, COMPTON, CONNELLY, DAILY, DARKO, DAVIS, DeBRUYCKER, DeMARS, DRISCOLL, ELLIOTT, ELLISON, EUDAILY, GERVAIS, GIACOMETTO, GILBERT, GLASER, GOOD, GOULD, GRADY, GRINDE, GUTHRIE, HANNAH, HANSEN S, HANSON M, HARPER, HARRINGTON, HAYNE, HOFFMAN, JOHNSON, KADAS, KASTEN, KELLER, KILPATRICK, KIMBERLEY, KNAPP, OEHNKE, LEE, MARKS, McCORMICK, McDONOUGH, MENAHAN, MERCER, MOORE, NELSON L, NELSON R, NELSON T, NISBET, O'KEEFE, OWENS, PATTERSON, PAVLOVICH, PECK, PETERSON, PHILLIPS, QUILICI, RAMIREZ, RANEY, REAM, REHBERG, RICE, ROTH, RUSSELL, SCHYE, SIMON, SIMPKINS, SMITH, SPAETH, SPRING, SQUIRES, STANG, STICKNEY, STRIZICH, SWIFT, SWYSGOOD, THOFT, THOMAS, WALLIN, WESTLAKE, WHALEN, WYATT, ZOOK, MR. SPEAKER.
TOTAL 96

NOES: NONE.
TOTAL 0

EXCUSED: BROWN D, IVERSON, O'CONNELL.
TOTAL 3

ABSENT OR NOT VOTING: STEPPLER.
TOTAL 1

PAIRED: NONE.

IN THE CHAIR: STANG.

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 33 concurred in by the following vote:

Ayes: Abrams, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 47

Noes: Aklestad, Mazurek, Tveit.
Total 3

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 60 concurred in by the following vote:

Ayes: Abrams, Anderson, Beck, Bengtson, Bishop, Blaylock, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Hofman, Jacobson, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail.
Total 43

Noes: Aklestad, Boylan, Himsl, Jenkins, Nathe, Mr. President.
Total 6

Excused: None.
Total 0

Absent or not voting: Severson.
Total 1

HB 80 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 87 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 89 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Hammond, Harding, Harp, Himsl, Hofman, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, Mazurek, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 50

Noes: None.
Total 0

Excused: None.
Total 0

Absent or not voting: None.
Total 0

HB 121 concurred in by the following vote:

Ayes: Abrams, Aklestad, Anderson, Beck, Bengtson, Bishop, Blaylock, Boylan, Brown, Crippen, Devlin, Eck, Farrell, Gage, Hager, Halligan, Harding, Harp, Himsl, Jacobson, Jenkins, Jergeson, Keating, Lynch, Manning, McLane, Meyer, Nathe, Noble, Norman, Pinsoneault, Pipinich, Rapp-Svrcek, Rasmussen, Regan, Severson, Stimatz, Story, Thayer, Tveit, Van Valkenburg, Vaughn, Walker, Weeding, Williams, Yellowtail, Mr. President.
Total 47

Noes: Hammond, Hofman, Mazurek.
Total 3

Excused: None.
Total 0

Absent or not voting: None.
Total 0

EXHIBIT 12
DATE 2-16-93
SB 347

HB 33

Exhibit #13

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 13
DATE 2/16/93
BILL NO. SB 347

apta

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
703/684-7343 Fax

Officers

Marilyn Moffat, PT, PhD, FAPTA
President

Jane M. Walter, PT, EdD
Vice President

Barbara A. Melzer, PhD, PT
Secretary

Donald E. Jackson, MS, PT
Treasurer

Cheryl J. Hill, MS, PT
Speaker of the House

Ben F. Massey, Jr, PT
Vice Speaker

Directors

Susan S. Deusinger, PhD, PT

Samuel B. Fertelberg, MA, PT

Janet L. Gwyer, PhD, PT

Jane E. Hogencamp, PT

Colleen M. Kigin, MPA, PT

Roger M. Nelson, PhD, PT

Blair J. Packard, MS, PT

Jan K. Richardson, PT, PhD, OCS

Joseph W. Smey, EdD, PT

Chief Executive Officer

William D. Coughlan, CAE

Eliminate Referral for Profit

The American Physical Therapy Association (APTA) urges Congress and the State legislatures to eliminate situations which we characterize as referral for profit. An increasing body of evidence is documenting the fact that huge amounts of money are unnecessarily being added to America's already bloated tab for health care. These unnecessary outlays are the result of situations in which health care practitioners invest in health care services and then profit by referring their patients to these services in which they have an investment interest.

These schemes assume various forms. Health care practitioners may become a limited partner in a physical therapy clinic, or they may form a joint venture with a physical therapist, or they might simply imply a physical therapist to whom they then refer their patients for physical therapy care. Regardless of the form the scheme assumes, the results are the same: referring practitioners position themselves to profit from the use of this authority to refer patients to other health care practitioners. Patients themselves can no longer assume that their well-being is the referring practitioner's motivation for ordering these additional services. Are they being referred simply because they need the services or might the referring practitioners' judgement be influenced by this opportunity to profit from these additional services?

A study conducted by the State of Florida's Health Care Cost Containment Board found that physician-owned physical therapy facilities provided 43% more visits per patient than did nonjoint venture physical therapy facilities. These additional visits generated 31% more revenue per patient. Subsequently, a study of this Florida data conducted by the Center for Health Policy Studies found that the estimated 1991 cost impact of physician joint ventures for imaging services, clinical laboratory tests and physical therapy services was a staggering $500.8 million.

Similar results were found across the country in a study of California's Workers' Compensation program. William M. Mercer, Inc. found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapy, that patient received a referral to physical therapy 66% of the time contrasted to 32% of the time when the initial provider had no ownership interest in physical therapy. The conclusion was that this self interest generated approximately $233 million in physical therapy services delivered for economic rather than clinical reasons.

The problem of referral for profit was recognized in a bipartisan manner during the 102nd Congress. Initiatives to restrict it were included in H.R. 5502, the health care reform legislation introduced by Rep. Pete Stark and House Majority Leader Richard Gephardt and in H.R. 5325, the house Republican Leadership health reform bill. Separate legislation, S. 3186, was also introduced by Senator Brock Adams. These initiatives died with the adjournment of Congress.

The APTA urges Congress resume its attention to this issue in 1993. The potential for abuse in these situations is high and the tremendous costs added to health care is completely unnecessary.

11/6/92

COMBINED SECTIONS MEETING
FEB. 3 - 7, 1993

EXHIBIT 13
DATE 2-16-93
SB 347

INCREASED COSTS AND RATES OF USE IN THE CALIFORNIA WORKERS' COMPENSATION SYSTEM AS A RESULT OF SELF-REFERRAL BY PHYSICIANS

ALEX SWEDLOW, M.H.S.A., GREGORY JOHNSON, PH.D., NEIL SMITHLINE, M.D., AND ARNOLD MILSTEIN, M.D., M.P.H.

Abstract *Background.* There is widespread concern that ownership by physicians of testing or treatment facilities to which they refer patients leads to overuse of such facilities. We determined the patterns of use of three services — physical therapy, psychiatric evaluation, and magnetic resonance imaging (MRI) — among physicians treating patients whose care was covered under workers' compensation. We then compared the rates of use among physicians who referred patients to facilities of which they were owners (self-referral group) with the rates among physicians who referred patients to independent facilities (independent-referral group).

Methods. We used a large data base to analyze claims under workers' compensation in California from October 1, 1990, through June 30, 1991, to determine the frequency and cost of these three selected services and determined whether the referring physicians were practicing self-referral or independent referral. We evaluated the cost per case for all three services, measured the frequency with which physical therapy was initiated, and evaluated the medical appropriateness of MRI.

Results. We found that physical therapy was initiated 2.3 times more often by the physicians in the self-referral group (68 percent) than by those in the independent-referral group (30 percent; $P<0.01$). The mean cost per case for physical therapy was significantly lower in the self-referral group ($404±102) than in the independent-referral group ($440±167; $P<0.01$).

The mean cost of psychiatric evaluation services was significantly higher in the self-referral group than in the independent-referral group (psychometric testing, $1,165±728 vs. $870±482; $P<0.01$; psychiatric evaluation reports, $2,056±1,063 vs. $1,680±578; $P<0.01$). The total cost per case of psychiatric evaluation services was 26.3 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; $P<0.01$).

Of all the MRI scans requested by the self-referring physicians, 38 percent were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group ($P<0.05$). There was no significant difference in the cost per case between the two groups.

Conclusions. This study demonstrates that self-referral increases the cost of medical care covered by workers' compensation for each of the three types of service studied. (N Engl J Med 1992;327:1502-6.)

THERE is growing concern about conflict of interest in medicine in the United States.[1-6] Recent studies have focused on whether physicians' ownership of testing or treatment centers increases the number of tests and services performed.[7-10] Research in Florida indicates that physician-owned facilities generate significantly higher rates of use and costs than independently owned facilities.[7,8] Studies of physician ownership in California have found that the higher concentration of physician-owned magnetic resonance imaging (MRI) facilities in California has increased rates of use between 34 percent and 56 percent above the rates for the rest of the country.[5] The study by Hillman et al. of diagnostic imaging demonstrated that physicians who referred patients to facilities of which they were owners (those who practiced self-referral) charged 4.4 to 7.5 times more per episode of care than other physicians.[10] In response to these findings, the states of Florida, Michigan, and New Jersey have enacted legislation that restricts self-referral by physicians.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs stated in December 1991: "In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[11] In June 1992, however, the AMA's House of Delegates adopted a new policy that allows doctors to make such referrals if patients are informed of the doctor's financial interest in the facility and of any available alternatives.[12] This reversal on the part of the AMA reflects the lack of consensus within organized medicine about physicians' ownership of medical facilities. There have also been two recent efforts by the federal government to limit self-referral on the part of physicians. Since January 1992, physicians have been prohibited from referring patients to clinical laboratories in which they have an ownership interest. In addition, the "safe harbor" regulations published in the *Federal Register* defined more clearly the investment, ownership, and reimbursement arrangements in which physicians may participate without fear of violating anti-kickback provisions of Medicare and Medicaid.[13]

To our knowledge, the effects of physician self-referral within the workers' compensation system have not been systematically analyzed. To investigate this issue, we evaluated a total of 6581 California workers' compensation cases for which claims were filed with a large workers' compensation insurance company during a nine-month period in 1990 and 1991. We analyzed the effect of physicians' self-referral on three high-cost medical services covered under workers' compensation: physical therapy, psychiatric evaluation, and MRI. We evaluated the cost per case for all three services, measured the frequen-

From the National Medical Audit unit, William Mercer, Inc., San Francisco (A.S., G.J., A.M.); and Current Health Concepts, Sausalito, Calif. (N.S.). Address reprint requests to Dr. Johnson at William Mercer, Inc., 3 Embarcadero Ctr., Suite 1250, San Francisco, CA 94111.

cy with which physical therapy was initiated, and prospectively analyzed the medical appropriateness of MRI.

Methods

This study was designed to compare the patterns of use of three services — physical therapy, psychiatric evaluation, and MRI — among physicians who refer patients to facilities of which they are owners (self-referral group) and physicians who refer patients to independent facilities (independent-referral group).

Since differences in case mix between physicians in the self-referral and independent-referral groups might account for differences in rates of use or cost, we classified all cases according to the Ambulatory Visit Groups (AVG) classification scheme,[14] which we have modified for workers' compensation cases.[15] The AVG system is analogous to the system of diagnosis-related groups currently used by Medicare to reimburse acute care hospitals. On the basis of the patient's diagnosis (the diagnostic code from the *International Classification of Diseases, 9th Revision, Clinical Modification*) and the medical-procedure codes of the California Relative Value Studies and *Current Procedural Terminology* for outpatient services in each case, the AVG system is used to assign that case to 1 (and only 1) of 571 groups.

Type of Referral

Throughout the study, self-referral was defined as a referral for a medical service made by a physician or clinic to an entity owned entirely or in part by the referring physician or clinic. Self-referral was defined by either of the following two patterns: referral services were provided under the same tax identification number as the primary service, or referral services were provided under a different tax identification number from the primary service, but one or more owners were common to both entities.

When services were delivered under different tax identification numbers, we searched commercially available data bases that list officers, stockholders, and partners of facilities (the California Fictitious Business Name Listing, the Executive Business Listing, and other state and national data bases on corporations and limited partnerships available from Information America, Atlanta). If this search failed to identify common ownership, we then directly telephoned the referring physician's office and inquired about common ownership.

Physical-Therapy and Psychiatric-Evaluation Services

We used one of California's largest data bases on workers' compensation claims (that of the Industrial Indemnity Co., San Francisco) to analyze the frequency and cost of physical-therapy and psychiatric-evaluation services provided to injured workers. The data base was selected because it was complete and contained information on a large number of patients distributed throughout California. Information about each case was stored longitudinally; thus, the data base contained claims information for all services provided to the injured worker during the entire nine-month period of the study.

Data on all patients covered by workers' compensation in California who received physical-therapy or psychiatric-evaluation services from October 1, 1990, through June 30, 1991, were analyzed. Our analysis compared the rates of use and costs of physical-therapy and psychiatric-evaluation services for physicians in the self-referral and independent-referral groups.

Since musculoskeletal injuries make up the majority of all workers' compensation medical cases, we were able to limit our evaluation of physical therapy to providers with substantial experience in treating industrial musculoskeletal injuries. We defined this degree of experience as the treatment of 10 or more cases of musculoskeletal injury during the study period. There were 76 providers who met this criterion; they treated 1257 cases of musculoskeletal injury. Using the method described above, we were able to determine in all instances whether the referring providers were in the self-referral group or the independent-referral group.

In California, patients covered by workers' compensation are most frequently referred for psychiatric-evaluation services to document a claim of "stress." This evaluation virtually always includes both psychometric testing and a psychiatric-evaluation report. (We documented this fact in a preliminary analysis of our data base.) We therefore limited our analysis of psychiatric-evaluation services to cases in which there was both psychometric testing and a psychiatric-evaluation report. Altogether, 1751 (39 percent) of the cases within the data base met this criterion. A random sample of 220 cases (13 percent) was selected for analysis of ownership. We were able to determine ownership and self-referral or independent-referral status in each of these cases.

MRI

We also compared the cost and appropriateness of MRI scans in the self-referral and independent-referral groups. Appropriateness of referral for an MRI scan was determined under a prospective precertification program. All physicians' requests for MRI scans (regardless of the body part to be examined) were referred by Industrial Indemnity to a national, independent utilization-review firm for precertification review of medical appropriateness. The firm's criteria for appropriateness were established by a panel of board-certified specialists in orthopedics, industrial medicine, and radiology. After initial development by an independent board-certified radiologist and the medical directors of the utilization-review firm and its parent (one of the three largest companies managing health maintenance organizations in the United States), the criteria were reviewed and revised by a panel of independent, practicing experts in managed care who were all board-certified in orthopedics, neurology, neurosurgery, or radiology.

On the basis of medical documentation of the patient's injuries and conversations with the physician who requested the MRI, the review firm gave an opinion on the medical appropriateness of the procedure before it was performed. The reviewers were blinded to the physician's relation with the MRI center.

The classification of a procedure as medically inappropriate could be appealed. To be certain that the reviewer's decision did not merely defer an appropriate scan to another date, cases in which the MRI was categorized as medically inappropriate were followed for an additional six months. In all cases in which a scan was approved within six months after the original request, the MRI was considered to be medically appropriate.

All 864 requests for MRI scans from January 1, 1991, through June 30, 1991, were evaluated. We were able to determine whether the physician had an ownership interest in the facility in 502 (58 percent) of these cases.

Statistical Analysis

Continuous variables are presented as means ±SD and were compared by two-tailed t-tests. The proportion of cases in each group was assessed by the chi-square test. For all analyses, a P value of less than 0.05 was considered to indicate statistical significance. Results were analyzed with use of the Crunch4 Statistical Package (Oakland, Calif.).

Results

Physical Therapy

Table 1 shows the 1257 cases of musculoskeletal injury (whether or not the patients received physical therapy) according to AVG and type of provider (whether the provider practiced self-referral or independent referral). Four AVGs account for 92 percent of all cases; there was no significant difference in the distribution of AVGs between the self-referral and independent-referral groups.

As shown in Table 2, physical therapy was initiated more than twice as often by physicians in the self-referral group (in 68 percent of the cases) as by those

EXHIBIT 13
DATE 2-16-93
SB 347
3

in the independent-referral group (30 percent; P<0.01). The mean cost per case for physical therapy in the self-referral group ($404±102) was significantly lower than that in the independent-referral group ($440±167; P<0.01).

Psychiatric-Evaluation Services

Table 1 classifies the random sample of 220 cases in which patients received both psychometric testing and psychiatric-evaluation services, according to AVG and provider type. There was no significant difference in the distribution of AVGs between the two types of providers. As Table 2 shows, the mean cost per case for psychiatric-evaluation services was 26 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; P<0.01). This difference was due to the higher cost of psychometric testing ($1,165±728 vs. $870±482; P<0.01) and the greater number of tests per case and to the higher costs of psychiatric-evaluation reports ($2.056±1,063 vs. $1,680±578; P<0.01) (since psychometric tests are reimbursed according to the California Official Medical Fee Schedule, which pays the same amount for each psychometric test regardless of the test, the cost per case for these reports is directly proportional to the number of tests performed).

Table 1. Distribution of AVGs and Mean Cost per Case in the Self-Referral and Independent-Referral Groups.*

AVG Code and Category	Cases		Cost per Case	
	Self-Referral	Independent Referral	Self-Referral	Independent Referral
	No. (%)		Mean ±SD ($)	
Physical therapy				
824 Medical back problems†	632 (62)	135 (56)	406±98	448±131
825 Tendonitis	162 (16)	43 (18)	384±119	451±177
829 Strain of arm or shoulder	87 (9)	18 (8)	413±68	360±234
826 Wound or fracture of arm or shoulder	58 (6)	18 (8)	381±122	401±188
828 Trauma to fingers or toes†	42 (4)	12 (5)	416±95	261±200
Other‡	36 (4)	14 (6)	444±111	789±1
Total‡	1017 (100)	240 (100)	404±102	440±167
Psychiatric services				
824 Medical back problems‡	61 (39)	24 (37)	3,230±1,493	2,340±697
2120 Minor wounds and injuries	58 (37)	18 (28)	3,215±1,420	2,887±743
1941 Individual supportive therapy	14 (9)	8 (12)	3,114±1,465	2,214±626
1945 Unscheduled crisis	10 (6)	3 (5)	2,929±1,153	2,314±929
1923 Other mental disturbances	6 (4)	7 (11)	4,372±1,967	2,744±748
Other	6 (4)	5 (8)	2,780±1,091	2,751±736
Total‡	155 (100)	65 (100)	3,222±1,450	2,549±742
MRI				
824 Medical back problems	273 (87)	165 (88)	981±231	994±171
829 Strain of arm or shoulder	30 (10)	14 (7)	936±179	874±79
Other	12 (4)	8 (4)	964±199	1,103±180
Total	315 (100)	187 (100)	976±226	990±170

*AVG denotes the Ambulatory Visit Groups classification.[14] There were no significant differences in the distribution of AVGs for physical therapy, psychiatric-evaluation services, or MRI between the self-referral group and the independent-referral group, by the chi-square test. Percentages do not always total 100, because of rounding.

†Differences in cost between the self-referral and independent-referral groups were significant (P<0.05) by t-test.

‡Differences in cost between the self-referral and independent-referral groups were significant (P<0.01) by t-test.

MRI Scans

Tables 1 and 2 show the results of our study of the medical appropriateness of MRI scans. A total of 502 requests for precertification were received from imaging centers in which ownership could be identified. In Table 1, these cases are classified according to AVG and provider type. There was no significant difference in the distribution of cases between the self-referral and independent-referral groups.

As shown in Table 2, 38 percent of the scans requested by physicians in the self-referral group were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group (P<0.05). There was no significant difference in cost per MRI procedure between the two groups.

Discussion

This study demonstrates that self-referral increases the cost of medical care under workers' compensation for each of the three types of service studied, but by a different mechanism in each instance: by substantially increasing the percentage of injured workers who receive physical therapy (which more than offsets the slight decrease in cost per case); by increasing the number of psychometric tests and the cost of psychiatric-evaluation reports; and by increasing the frequency of requests for clinically inappropriate MRI scans. These higher rates of use and higher costs have important implications for workers' compensation expenditures, since self-referral is the predominant form of referral for these services.

Physical Therapy

According to the California Workers' Compensation Institute (CWCI) 1990 Medical Fee Survey of 39 private and public insurers, physical therapy represents 56 percent of all outpatient procedures and 34 percent of all outpatient costs for the treatment of injured workers in California.[16] This represents an increase of 31 percent in the volume of services in relation to other outpatient procedures since the CWCI's 1988 study.[16]

Injured workers usually receive a prescription for treatment from a physician (an orthopedic specialist or physician at an industrial medical or multispecialty clinic) to the physical therapist for specific treatment. Over the years, many physicians and clinics that treat patients covered by workers' compensation have established physical-therapy departments within their general operations or have established separate phys-

Table 2. Frequency of Use of Services and Cost per Case in the Self-Referral and Independent-Referral Groups.

Variable	Cases			Cost per Case		
	Self-Referral	Independent Referral	Self-/Independent Ratio*	Self-Referral	Independent Referral	Self-/Independent Ratio*
	no. (%)			mean ±SD ($)		
Physical therapy						
No. of musculoskeletal injuries	1017 (100)	240 (100)	—	—	—	—
Cases with physical therapy	690 (68)†	71 (30)	2.3	404±102‡	440±167	0.9
Psychiatric services						
Cases with psychiatric-evaluation reports	155 (100)	65 (100)	—	2,056±1,063‡	1,680±578	1.2
Cases with psychometric testing	155 (100)	65 (100)	—	1,165±728‡	870±482	1.3
Cost of total evaluation	—	—	—	3,222±1,451‡	2,550±742	1.3
MRI						
Requests for scans	315 (100)	187 (100)	—	—	—	—
Scans found medically inappropriate	121 (38)§	52 (28)	1.4	976±226	990±170	1.0

*The ratio of the number of cases or the cost per case in the self-referral group to that in the independent-referral group.

†The proportion of cases in which physical therapy was ordered in the self-referral and independent-referral groups differed significantly ($P<0.01$), by the chi-square test.

‡The mean cost per case differed significantly between the self-referral group and the independent-referral group ($P<0.01$), by t-test.

§The proportion of cases in which MRI scans were found to be medically inappropriate differed significantly between the self-referral group and the independent-referral group ($P<0.05$), by the chi-square test.

ical-therapy facilities that they own but that are operated as distinct financial entities.

In Florida, Mitchel and Scott recently found that 40 percent of physical-therapy facilities were owned by physicians.[7] Our study focused on California physicians who treat large numbers of musculoskeletal injuries and found that 91 percent of all physical therapy was performed by providers who engage in self-referral (Table 2), and the frequency with which physical therapy was initiated was 2.3 times greater in the self-referral group than the independent-referral group. The cost per case of physical therapy, however, was about 10 percent higher in the independent-referral group.

In this study, there was no significant difference in case mix between the self-referral and independent-referral groups (Table 1). In the absence of measures of severity of illness among outpatients, it is therefore impossible to determine whether the lower cost per case in the self-referral group reflects more efficient care or the provision of physical therapy to patients with less severe injuries, since self-referring practitioners initiate physical therapy at more than twice the rate of independent providers.

Regardless of which hypothesis is correct, this small difference in cost per case is more than offset by the dramatically greater frequency with which self-referring providers initiate physical therapy. As Table 3 shows, for every 1000 workers with musculoskeletal injuries, the costs incurred by the California workers' compensation system would be $143,672 (110 percent) higher if these injured workers were evaluated by self-referring rather than independently referring practitioners.

Psychiatric-Evaluation Services

The CWCI estimates that approximately 6 percent of the total medical payments under workers' compensation were for psychiatric services in 1991.[16] California state law defines a valid claim of work-related stress as one in which the work environment contributes 10 percent or more to a worker's total stress level. Some argue that this definition of compensable workplace stress has created a referral environment that encourages excessive evaluation and testing.

We found that 70 percent of all psychiatric-evaluation services were requested by providers who had an ownership interest in the entity that provided both psychometric testing and psychiatric-evaluation reports (Table 2). Furthermore, evaluation costs were 26 percent higher when this ownership relation existed.

As indicated above, a referral for evaluation virtually always results in charges for two services: psychometric testing and a psychiatric-evaluation report that synthesizes the findings of the psychometric tests with the findings from the psychiatric history and examination. Therefore, if a provider with an economic interest in a facility were motivated more by monetary incentives than one without such an economic interest, we would expect this to be reflected in greater use and higher costs of psychometric testing, as well as a more extensive and therefore more costly evaluation report, which would be required to integrate the results of more extensive testing. As shown in Table 2, the cost of each psychiatric service and the mean cost per case were significantly higher in the self-referral group than the independent-referral group; the differences in cost were as follows: psychometric testing, 34 percent; psychiatric evaluation reports, 22 percent; and total evaluation, 26 percent.

As Table 3 shows, for every 1000 workers receiving psychiatric-evaluation services, the costs incurred by the California workers' compensation system would be $672,000 (26 percent) higher if these workers were treated by physicians in the self-referral group rather than the independent-referral group.

MRI Scans

MRI has gained prominence as the diagnostic imaging tool of choice in the assessment and documentation of specific types of injuries. California cur-

Table 3. Additional Cost Incurred by the California Workers' Compensation System for Each 1000 Injuries Treated at Self-Referral Rather Than Independent-Referral Rates.

Service	Self-Referral	Independent Referral
Physical therapy		
No. of musculoskeletal injuries	1000	1000
Rate of referral for physical therapy	× .678	× .296
No. of cases with physical therapy	678	296
Cost per case	× $404	× $440
Total cost of physical therapy	$273,912	$130,240
Additional cost per 1000 cases (%)	$143,672 (110)	
Psychiatric services		
No. of cases with psychiatric-evaluation services	1000	1000
Cost per case	× $3,222	× $2,550
Total cost of psychiatric-evaluation services	$3,222,000	$2,550,000
Additional cost per 1000 cases (%)	$672,000 (26)	
MRI		
No. of requests for MRI	1000	1000
Rate of inappropriate scans	× .384	× .278
No. of inappropriate scans	384	278
Cost per case	× $976	× $990
Cost of inappropriate MRI	$374,784	$275,220
Cost differential for appropriate scans*	—	$10,108
Total cost of MRI scans	$374,784	$285,328
Additional cost per 1000 cases (%)	$89,456 (31)	

*Additional cost ($14 per case) of the 722 approved MRI procedures.

rently has approximately 400 MRI machines (Mitchel J: personal communication). Recent studies have shown that such a concentration of imaging centers is associated with higher rates of use. After adjustment for the characteristics of the population, Californians undergo 51 percent more MRI procedures than the national average.[9] Leape et al. similarly concluded that an increased concentration of providers increases rates of use.[17] In their study, regions with a high rate of carotid endarterectomy had twice as many surgeons performing the operation as regions where the rate was low.

We found MRI scans to be medically inappropriate 38 percent more often when ordered by self-referring physicians, suggesting increased rates of use in this group. The higher rate of inappropriateness in the self-referral group may help explain the Florida study's finding that rates of use in these physician-owned facilities were 14 to 65 percent higher than in a control area.[7]

Table 3 illustrates the effects of these requests for medically inappropriate scans. For every 1000 requests for MRI scans, the costs incurred by the California workers' compensation system would be $89,456 (31 percent) higher if these requests were made by self-referring physicians rather than by physicians in the independent-referral group.

We are indebted to Mr. Will B. Murphey for his support and encouragement in this project.

References

1. Relman AS. Dealing with conflicts of interest. N Engl J Med 1985;313:749-51.
2. Iglehart JK. Efforts to address the problem of physician self-referral. N Engl J Med 1991;325:1820-4.
3. Financial arrangements between physicians and health care businesses: report to Congress. Bethesda, Md.: Department of Health and Human Services, Office of Inspector General, 1989.
4. Morreim EH. Physician investment and self-referral: philosophical analysis of a contentious debate. J Med Philos 1990;15:425-48.
5. Relman AS. What market values are doing to medicine. Atlantic Monthly. March 1992:99-106.
6. Waldholz M, Bogamch W. Warm bodies: doctor owned labs earn lavish profits in a captive market. Wall Street Journal. February 27, 1989: 1.
7. Mitchell JM, Scott E. Joint ventures among health care providers in Florida. Vol. 2. Contract report for Florida Health Care Cost Containment Board. September 1991. Tallahassee: State of Florida, 1991.
8. Dyckman Z. Impact of physician joint venture activity on medical care costs in Florida. Columbia, Md.: Center for Health Policy Studies, 1992.
9. *Idem.* Impact of physician joint venture activity on costs of diagnostic imaging services in California. Columbia, Md.: Center for Health Policy Studies, 1992.
10. Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice — a comparison of self-referring and radiologist-referring physicians. N Engl J Med 1990;323:1604-8.
11. Council on Ethical and Judicial Affairs, American Medical Association. Conflicts of interest: physician ownership of medical facilities. JAMA 1992; 267:2366-9.
12. A.M.A. eases policy on self-referrals. New York Times. June 24, 1992: A12.
13. Department of Health and Human Services. Medicare and state health care programs: fraud and abuse; OIG anti-kickback provisions. Fed Regist 1991;56(145):35952-87.
14. Schneider K, Lichtenstein JL, Ferrer RB, Freeman JL, Newbold RC. The new ICD-9-CM ambulatory visit groups classification scheme definitions manual. New Haven, Conn.: Yale University Press, 1986.
15. Smithline N, Swedlow A, Johnson G, Nethercut G, Selbovitz LG. Outpatient surgery for injured workers. J Ambulatory Care Manage 1990;13:47-53.
16. Jones M. Medical fees, 1990. San Francisco: California Workers' Compensation Institute, 1991 (executive memo).
17. Leape LL, Park RE, Solomon DH, Chassin MR, Kosecoff J, Brook RH. Relation between surgeons' practice volumes and geographic variation in the rate of carotid endarterectomy. N Engl J Med 1989;321:653-7.

EXHIBIT 13
2-16-93
SB 347

EXHIBIT 13
DATE 2-16-93
SB 347

SPECIAL ARTICLES

CONSEQUENCES OF PHYSICIANS' OWNERSHIP OF HEALTH CARE FACILITIES — JOINT VENTURES IN RADIATION THERAPY

JEAN M. MITCHELL, PH.D., AND JONATHAN H. SUNSHINE, PH.D.

Abstract *Background.* Physicians are increasingly the owners of health care facilities to which they refer patients for services but at which they do not practice. We studied such ownership arrangements, known as "joint ventures," in the field of radiation therapy, examining their effects on access, use of services, costs, and quality.

Methods. Because 44 percent of free-standing facilities providing radiation therapy in Florida in 1989 were joint ventures, as compared with 7 percent elsewhere (95 percent confidence interval, 3 to 10 percent), we compared data for Florida with comparable data for the remainder of the United States. We also compared radiation-therapy facilities in Florida that were established as joint ventures with those that were not. Since most data were derived from entire populations rather than from samples, any differences found were of necessity statistically significant.

Results. No joint-venture facilities providing radiation therapy were located in inner-city neighborhoods or rural areas, but 11 percent of other free-standing facilities and hospital-based facilities were located in such areas. Among free-standing facilities, joint ventures received 39 percent of their revenues from patients with well-paying insurance coverage, as compared with 31 percent for facilities that were not joint ventures ($P<0.01$). The frequency and costs of radiation-therapy treatments at free-standing centers were 40 to 60 percent higher in Florida than in the rest of the United States; there was no below-average use of radiation therapy at hospitals or higher cancer rates that explained the higher rates of use or higher costs in Florida. Radiation physicists at joint-venture facilities (the principal personnel involved in quality control other than physicians) spent 18 percent less time with each patient over the course of treatment than did their counterparts at free-standing facilities that were not joint ventures ($P<0.05$). Mortality among patients with cancer in Florida was not lower than the U.S. average, even though joint ventures are much more common in that state.

Conclusions. Joint ventures in radiation therapy appear to have adverse effects on patients' access to care. They also appear to increase the use of services and costs substantially. Some indicators show that joint ventures cause either no improvement in quality or a decline. Our results add to the evidence indicating that physicians' self-referral generally has negative consequences. We recommend legislation to ban ownership of joint ventures by referring physicians. Such legislation needs to be carefully designed in order to achieve its objectives and forestall new, financially abusive arrangements. (N Engl J Med 1992;327:1497-501.)

UNDER federal law, it is illegal for physicians to receive kickbacks for referrals of Medicare and Medicaid patients. Thirty-six states also have anti-kickback laws of various types that apply to both publicly and privately insured patients. General prohibitions of referrals to facilities in which physicians have a financial interest are uncommon, however.[1,2] Nonetheless, in recent years physicians have come to own nearly every type of health care business to which they make referrals, but at which they do not directly provide services.[3] Some critics argue that such arrangements, known as "joint ventures," have proliferated because they are lucrative investments from which the referring physicians are able to earn disguised kickbacks.[4]

Critics contend that the financial incentives for referring physicians that are created by joint ventures lead to overuse of services, increased costs to consumers, reduced access for the poor, and service of diminished quality.[5-8] Proponents claim that joint ventures may increase access to care for persons in medically underserved areas, may provide needed financing, and may allow physicians to improve the quality of the services provided to their patients.[9,10] Despite intense debate, there is little empirical evidence of the effects of joint ventures involving physicians.

This study uses recent data, principally from Florida, to examine the effects of joint ventures in radiation therapy. Previous research on the effects of physicians' financial interests has concentrated on use of services and costs.[11-15] We examine a broader range of effects, including those on access and (to a more limited extent) quality, in accordance with a recent study conducted by one of us.[16] The examination of data from Florida is particularly appropriate, because a large proportion of the free-standing radiation-therapy centers there are owned by referring physicians. In contrast, joint-venture centers providing radiation therapy were rare elsewhere before 1991. Thus, comparing the situation in Florida with that in other states constitutes something of a natural experiment.

METHODS

All free-standing facilities providing radiation therapy and all acute care general hospitals in Florida were sent questionnaires as part of a comprehensive study of health care facilities commissioned by the Florida legislature.[16] Twenty-three of the 52 free-standing facilities (72 percent) provided information on ownership, staffing, and revenue according to category of payer; facilities that

From the Graduate Public Policy Program, Georgetown University, Washington, D.C., and the Department of Economics, Florida State University, Tallahassee (J.M.M.), and the Research Department, American College of Radiology, Reston, Va. (J.H.S.). Address reprint requests to Dr. Mitchell at the Graduate Public Policy Program, Georgetown University, 3600 N St., NW, Suite 200, Washington, DC 20007.

did not respond were contacted by telephone for information about their ownership. Over 95 percent of the 238 acute care licensed hospitals returned the surveys, from which we identified 39 hospital-based departments providing radiation therapy.

The free-standing facilities were classified according to ownership status as either joint ventures or non-joint ventures. The term "joint venture" was defined to indicate any ownership or investment interest between a referring physician (or other health care professional making referrals) and a business providing radiation-therapy services. Because radiation oncologists are consultative physicians who receive and treat patients referred by other physicians, radiation-therapy centers owned solely by such specialists are not joint ventures. Joint ventures located outside Florida that provided radiation therapy were identified by tabulating data from the 1989 Group Practice Survey of the American College of Radiology.[17]

Access

We compared joint ventures with other facilities providing radiation-therapy services in Florida in order to evaluate geographic access — that is, whether any facilities were located in inner-city neighborhoods or outside urban areas. In accordance with the practice of Florida's Department of Health and Rehabilitative Services, we defined urban areas to include metropolitan statistical areas (as designated by the U.S. Census Bureau) and counties with a population in excess of 100,000 persons.

We also evaluated economic access by comparing the percentage of revenues derived from well-paying sources with that derived from poorly paying sources. Managed care payers, Blue Cross, and commercial insurers were classified as well-paying sources, because during 1989 these payers reimbursed, on average, about 90 percent of the submitted charges. In contrast, during 1989 Medicaid reimbursements for radiation-therapy services averaged between 5 and 10 percent of the full charges, Medicare reimbursements averaged approximately 70 percent, and patients nominally paying their own bills were typically recipients of charity care. These were classified as poorly paying revenue sources.

Use of Services

Radiation therapy for cancer has become somewhat standardized as a result of the Patterns of Care study.[18-20] Hence, any variations in use associated with joint ventures are likely to result more from different numbers of patients receiving treatment than from changes in the number of services per patient treated. Radiation therapy thus offers an interesting contrast to clinical laboratory services, in which investors who are referring physicians can easily increase the use of services not only by ordering tests for more of their patients, but also by ordering more tests per patient.

We evaluated the effects of joint ventures on the use of services by taking a market-area approach.[21,22] Specifically, we measured the use of radiation-therapy services per Medicare beneficiary in Florida and compared these figures with corresponding data for the rest of the United States. Such ratios of use to population take into account differences both in the percentage of patients receiving treatment and in the number of services provided to each such patient.

An analysis of Medicare data is particularly appropriate in the case of radiation-therapy services because cancer, the disease that is treated by radiation therapy, is very much a disease of the elderly (persons 65 years of age or older). The source of data used to study use of services and costs was the procedure file of Part B Medicare Annual Data for 1989. This file contains data on all physicians' services provided under Medicare, including the number of services, the charges submitted, and the amounts paid according to procedure, locality and state, and place of service (i.e., hospital or nonhospital), and other variables.

Two measures of use were employed: the number of radiation-therapy services per 1000 Medicare enrollees and the number of relative-value units for radiation therapy per 1000 Medicare enrollees. To standardize the count of services, each "weekly treatment management" service (codes 77420 to 77430 of *Current Procedural Terminology*, fourth revision [CPT-4]) was counted as five services, in accordance with Medicare's definition of weekly treatment management.[23] The Medicare relative-value scale for radiation-therapy services was developed by radiation oncologists. A relative-value scale recognizes the amount of work involved in providing each individual service and thus represents a more refined measure of use than a simple count of services.[24] The use of hospital-based facilities, which may serve as a substitute for the use of free-standing centers, was measured in the same two ways.

We also compared both the incidence of cancer and mortality from cancer in the Florida elderly population in 1989 with the corresponding statistics for the entire United States, since these factors could underlie differences in service use. Data on cancer in Florida were obtained from the Florida Department of Health and Rehabilitative Services. National data were obtained from the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute, with the incidence data for 1984 through 1988 extrapolated to 1989,[25] and from the National Center for Health Statistics (for 1989 death rates). With respect to age and sex, the composition of the Florida elderly population was almost identical to that of the overall U.S. elderly population, so no adjustments for age or sex were made to the data on use of services or cancer rates.

Costs

We compared the Medicare Part B data on submitted charges and amounts reimbursed by Medicare (the so-called "allowed charges") for all radiation-therapy procedures rendered in free-standing facilities in Florida with the corresponding figures for the rest of the United States. Free-standing facilities charge a global fee that includes both the physician's "professional component" and the technical or facility component. Submitted charges and payments for radiation-therapy procedures performed in hospitals were not analyzed, because the Medicare Part B file contains only the physician's professional component.

Quality

We evaluated the use of time by radiation physicists, the nonphysician personnel most responsible for quality control. Specifically, we compared joint ventures and non-joint ventures with respect to physicists' hours of work per patient treated in free-standing facilities. We also compared outcomes of cancer in Florida with those in the United States as a whole. The outcome measure was an approximation of the cancer lethality rate, calculated as the number of cancer deaths in 1989 divided by the 1989 incidence rate for cancer. Since outcomes of cancer differ according to age and sex, and this measure may be sensitive to very small differences, we adjusted the U.S. nationwide data to the age- and sex-related mix of Florida's elderly population before computing the U.S. lethality rate. The statistic we used was not a strict case fatality rate. For example, some of the 1989 cancer deaths involved patients who were first given their diagnoses in earlier years. However, since incidence and death rates change slowly, a comparison of our statistic across geographic areas provides a reasonable measure of relative outcomes.

Statistical Analysis

Percentages of revenue derived from high-paying sources and physicists' time spent per patient were compared by two-tailed t-tests. Since the sample of radiation-therapy facilities represented a large percentage of the total number, we applied the usual finite-population correction factor to adjust the standard errors of these variables. The Medicare data represented the entire population, rather than a sample. In such cases, the usual view of statisticians is that tests of significance are not required, because all differences found are real.[26]

Results

During 1989, 14 of the 32 free-standing radiation-therapy facilities in Florida (44 percent) were joint ventures. Tabulations from the 1989 Group Practice Survey of the American College of Radiology show that elsewhere in the United States, 7 percent of such

EXHIBIT 13
2-16-93
SB 347

centers (95 percent confidence interval, 3 to 10 percent) were joint ventures.

Access

None of the joint ventures among the free-standing radiation-therapy centers in Florida were located in a rural county or an inner-city neighborhood. In contrast, 1 of the 18 free-standing centers that were not joint ventures (6 percent) was located in a rural county, and 5 of the 39 hospital-based facilities (13 percent) were situated in inner-city neighborhoods.

With respect to economic access, we found that among free-standing facilities in Florida, the joint ventures generated 39 percent of their revenues from high-paying sources. In comparison, free-standing centers that were not joint ventures derived 31 percent of their revenues from such sources ($P<0.01$).

Use of Services

At free-standing centers, the number of radiation-therapy procedures per 1000 Medicare enrollees was 58 percent higher, and the number of relative-value units for radiation therapy 53 percent higher, in Florida than the average in the rest of the United States (Table 1).

The frequency with which radiation therapy was administered in hospital-based facilities, measured by a count both of procedures and of relative-value units, was slightly higher in Florida than in the rest of the United States (Table 2). The higher volume of services performed in hospitals as compared with free-standing centers, both in Florida and nationally, does not imply that hospitals use more resources to treat patients. Instead, it probably indicates that there are more hospital-based facilities than free-standing centers. The incidence of cancer among the elderly in Florida and the mortality rate from cancer were, respectively, 8 and 6 percent below the national average (Table 3).

Costs

For every 1000 Medicare enrollees, the submitted charges for radiation therapy performed in free-standing centers in Florida exceeded the submitted charges for the rest of the United States by 42 percent ($13,290 vs. $9,572) (Table 1). A similar comparison of the amount actually paid by Medicare (the "allowed charges") shows that in Florida, Medicare payments for radiation therapy provided in free-standing centers exceeded the average payments elsewhere by almost 46 percent ($9,572 per 1000 enrollees in Florida vs. $6,556 nationally).

Quality

Among free-standing facilities, the joint ventures used radiation physicists 18 percent less than facilities that were not joint ventures. They averaged 4.78 hours of physicist time per patient treated, as compared with 5.82 hours for free-standing facilities that were not joint ventures ($P<0.05$). Approximately 54 percent of patients with cancer died of their disease in Florida, as compared with 53 percent nationally (Table 3). Adjustments for age and sex made a difference of approximately 0.1 percent in this measure of lethality.

Table 1. Cost and Frequency of Radiation-Therapy Services Provided in 1989 at Free-Standing Centers, per 1000 Medicare Enrollees.

Measure	No. of Procedures	No. of Relative-Value Units	Charges ($)	
			Submitted	Allowed
Florida	139	1165	13,290	9,572
Rest of U.S.	88	762	9,328	6,556
Excess, Florida over rest of U.S. (%)	58	53	42	46

Discussion

Findings in Florida

Our analysis of Florida shows that free-standing radiation-therapy facilities owned by referring physicians provide less access to poorly served populations than other types of radiation-therapy facilities. Geographically, hospitals provide the most ready access for such populations, because a considerable percentage of hospitals are located in inner-city neighborhoods. Economically, joint ventures "skim the cream," because they generate substantially more of their revenues from patients with good insurance than do free-standing centers that are not joint ventures. The disparity we measured would probably have been even greater if we had data on sources of revenue for

Table 2. Frequency of Radiation-Therapy Services Provided in 1989 at Hospitals, per 1000 Medicare Enrollees.

Measure	No. of Procedures	No. of Relative-Value Units
Florida	186	769
Rest of U.S.	182	673
Excess, Florida over rest of U.S. (%)	2	13

Table 3. Cancer Rates among the Elderly in 1989.

Measure	Florida	Entire United States	Difference (%)
	per 1000 elderly		
Incidence	18.82	20.52	−8
Death rate	10.24	10.85	−6
Synthesized lethality rate*	54.4	52.8	+3

*Equals the death rate divided by the incidence rate. For the United States, the rate shown was derived after standardization of the U.S. population to the composition of the elderly population in Florida with respect to age and sex. Without such standardization, the rate for the United States would be 52.9 percent.

hospital-based facilities, many of which are located in inner cities. "Cream skimming" tends to undermine the financial base of facilities that are more willing to treat poorly insured patients.

Since 44 percent of the free-standing facilities in Florida were joint ventures, as compared with 7 percent elsewhere, joint ventures must be regarded as a likely explanation for the high levels of use and costs characteristic of Florida. Moreover, we investigated the two most obvious alternative explanations: that free-standing centers substitute for hospital-based facilities and that cancer is more common in Florida than elsewhere. Our analyses show that neither of these explanations is valid. Indeed, since the use of hospital-based radiation-therapy services was slightly higher in Florida than elsewhere in the United States and the burden of cancer lower, these factors should lead to lower use and costs at free-standing centers in Florida.

A replication of the analysis of use of services with 1988 data showed that rates of use in Florida were at least as far above the U.S. average in 1988 as in 1989. Therefore, the 1989 findings were not a onetime occurrence. Since use of services and costs at free-standing facilities are about equally elevated in Florida, the increase in use is probably the principal cause of the higher costs.

Other evidence supports the contention that joint ventures are responsible for the increase in service use and costs. Several recent studies have found that when physicians gain financially from the provision of services, as is the case with joint ventures, service use and costs are substantially higher.[1,11-14,16] In one case in Florida, a radiation oncologist in an academic center reported that in an area where approximately 80 patients per day had received radiation therapy, the number increased to approximately 110 after the opening of a free-standing facility owned by some 175 referring physicians.[27] Additional case studies of this sort would help resolve the issue of causality more definitively. Currently, Florida's high rate of use of services and costs could possibly be explained by factors other than joint ventures. For example, physicians in the state may provide more services for all kinds of illnesses, with radiation therapy being only an example of this pattern. Nonetheless, joint ventures are extremely common in Florida in many types of health care services,[5] and this might well account for a generally higher use of services.

Our evidence with regard to quality is quite limited. Traditionally, quality has been conceptualized as consisting of a number of factors related to structure, process, and outcome. We measured only one structure variable (staffing with physicists) and one outcome variable (the percentage of patients with cancer who die of their disease). The structural measure suggests that quality is lower in joint ventures. Our outcome measure was probably not particularly sensitive, because many patients with cancer receive no radi- [illegible] Still, it is clear that mortality from cancer in Florida has not declined substantially, despite the many joint ventures in the state.

Policy Considerations

At its annual meeting in December 1991, the American Medical Association (AMA) adopted new guidelines on joint ventures, specifying that "physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[28] An exception was made for facilities established both because there is a demonstrated need in the community and because alternative financing is not available. The AMA emphasized that a physician's professional obligation is to the well-being of the patient and that the financial interest created by joint ventures results in at least the appearance of a conflict of interest.

Our findings documenting the generally negative consequences of joint ventures in radiation therapy, the similar findings of others on the effect of physicians' financial interests,[1,11-14,16] and the conflict of interest inherent in self-referral by physicians all lead us to conclude that joint ventures involving referring physicians should be made illegal. The AMA's repudiation of its strong stance in June 1992 shows that professional guidelines are a weak reed. The existing federal anti-kickback law is in itself not an adequate remedy, if only because most patients are not covered by Medicare or Medicaid, and therefore the federal law does not apply to them. Banning joint ventures should substantially mitigate the continued escalation of health care costs. Such prohibitions have been recommended by President George Bush as part of his comprehensive program of health care reform.[29] Bans on physicians' joint ventures, covering various types of services, were enacted this year in Illinois, Florida, and New York.

For such laws to be effective, they must include a requirement for the reasonably prompt divestiture or dissolution of existing joint ventures. For example, the federal ban on joint ventures involving clinical laboratories allowed two years for divestiture or dissolution.[8] Provisions that allow "grandfathering" over the long or moderately long term only perpetuate deleterious effects. Also, the laws must effectively prevent new forms of abuse. If joint ventures are clearly outlawed and actively prosecuted, we expect to see attempts to achieve the same inappropriate financial gains through legal stratagems intended to make a facility to which a physician refers patients appear to be part of the physician's own practice.

References

1. Financial arrangements between physicians and health care businesses: report to Congress. Bethesda, Md.: Department of Health and Human Services, Office of Inspector General, 1989.
2. Financial arrangements between physicians and health care businesses: state laws and regulations. Bethesda, Md.: Department of Health and Human Services, Office of Inspector General, 1989.

not detected by current assays may yet be found in both serum and cryoprecipitates.

The possibility that HCV infection is responsible for many or perhaps most cases of Type II and Type III cryoglobulinemia has therapeutic implications. In the past, treatment with plasmapheresis or plasma exchange plus corticosteroids or cytotoxic drugs was reserved for patients with severe manifestations, such as vascular insufficiency, renal failure, and progressive involvement of the peripheral nerves. Combined treatment was often remarkably effective under these circumstances, but it was less effective in patients with smoldering renal or neurologic involvement or painful episodes of cutaneous vasculitis. The favorable results of treatment of mixed cryoglobulinemia with interferon alfa are encouraging[9]; this drug should be subjected to multicenter controlled therapeutic trials to determine its efficacy in mixed cryoglobulinemia due to HCV infection.

Several viruses have also been implicated in the pathogenesis of Sjögren's syndrome,[10] but there is no rigorous proof of an etiologic role for any of them. The finding of HCV RNA in the serum of three of four patients raises this issue anew. Possibly, HCV will prove to be the etiologic agent of Sjögren's syndrome, or perhaps HCV is merely another virus capable of infecting salivary and lacrimal glands to produce a clinical and histologic picture resembling idiopathic Sjögren's syndrome.

Meticulous adherence to the proper methods of collecting and processing samples is essential to the detection of cryoprecipitable substances in serum. At least 20 ml of blood (large amounts enhance the likelihood of detecting small amounts of cryoprecipitate) should be taken from a fasting patient (lipids may interfere with the test by precipitating in the cold). The blood (not treated with an anticoagulant) is placed in tubes in warm water and transported promptly to the laboratory. Once there, it is allowed to clot at 37°C for 1 hour and then separated in a warm centrifuge; the clear serum supernatant is removed and stored at 4°C for 72 hours. The serum is examined daily for cryoprecipitate. If any is detected, the amount of cryoprecipitate (the cryocrit) is determined, and the carefully washed cryoprecipitate is dissolved by warming. Its constituents are then identified by immunodiffusion. Delay in the transport or refrigeration of the sample before processing will lead to the loss of cryoprecipitable substances in the clot, which is discarded when serum is obtained. Hence, in most instances, blood to be examined for cryoprecipitable substances should not be drawn when the laboratory is closed or about to close.

Finally, in view of the demonstration of HCV RNA in the cryoprecipitate from many patients with Type II and Type III cryoglobulinemia, the term "cryoglobulin" no longer accurately describes the cold-precipitable substances recoverable from serum. The phenomenon is once again in search of a name.

Massachusetts General Hospital
Boston, MA 02114

KURT J. BLOCH, M.D.

REFERENCES

1. Lerner AB, Watson CJ. Studies of cryoglobulins. I. Unusual purpura associated with the presence of a high concentration of cryoglobulin (cold precipitable serum globulin). Am J Med Sci 1947;214:410-5.
2. Brouet J-C, Clauvel J-P, Danon F, Klein M, Seligmann M. Biologic and clinical significance of cryoglobulins: a report of 86 cases. Am J Med 1974; 57:775-88.
3. Wang A-C. Molecular basis for cryoprecipitation. Springer Semin Immunopathol 1988;10:21-34.
4. Gorevic PD, Kassab HJ, Levo Y, et al. Mixed cryoglobulinemia: clinical aspects and long-term follow-up of 40 patients. Am J Med 1980;69:287-308.
5. Montagnino G. Reappraisal of the clinical expression of mixed cryoglobulinemia. Springer Semin Immunopathol 1988;10:1-19.
6. Levo Y, Gorevic PD, Kassab HJ, Zucker-Franklin D, Franklin EC. Association between hepatitis B virus and essential mixed cryoglobulinemia. N Engl J Med 1977;296:1501-4.
7. Popp JW Jr, Dienstag JL, Wands JR, Bloch KJ. Essential mixed cryoglobulinemia without evidence for hepatitis B virus infection. Ann Intern Med 1980;92:379-83.
8. Agnello V, Chung RT, Kaplan LM. A role for hepatitis C virus infection in Type II cryoglobulinemia. N Engl J Med 1992;327:1490-5.
9. Bonomo L, Casato M, Afeltra A, Caccavo D. Treatment of idiopathic mixed cryoglobulinemia with alpha interferon. Am J Med 1987;83:726-30.
10. Fleischer E, Talal N. Do viruses contribute to the development of Sjögren's syndrome? Am J Med 1991;90:253-5.

"SELF-REFERRAL" — WHAT'S AT STAKE?

"SELF-REFERRAL" is the term used to describe a physician's referral of patients to an outside facility in which he or she has a financial interest but no professional responsibility. This practice has become particularly prevalent in certain parts of the country, where for-profit imaging centers, diagnostic laboratories, home health care services, radiotherapy centers, physiotherapy units, and other free-standing facilities have been soliciting investments by physicians who can refer patients to them. Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. The contentious and emotional debate that has been waged over this issue reflects the increasing tension between professional and business values in medicine.[1]

In December 1991, the American Medical Association (AMA) seemed finally to have ended years of ambivalence and uncertainty about self-referral when its House of Delegates approved without dissent a report from the Council on Ethical and Judicial Affairs.[2] Taking a strong stand on the side of professional values, the council advised physicians to avoid self-referral, except when there is a demonstrated need in the community for the facility and alternative financing is not available. The council acknowledged the mounting evidence of excessive costs and rates of use in jointly owned for-profit facilities but emphasized that it was primarily concerned about the integrity of the profession. The following passage from the report expresses its essential message:

> At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply business people with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than

EXHIBIT 13
DATE 2-16-93
SB 347

ever the most ethical business person. . . . There are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse.[2]

This admirable statement supports a position I have repeatedly advocated for more than a decade[3-6] — one that was also strongly recommended by the Institute of Medicine in its 1986 report on for-profit enterprise in health care.[7]

Coming on the heels of recent similar statements on self-referral by such other major medical organizations as the American College of Physicians, the American College of Surgeons, and the American College of Radiology, the council's report and its endorsement by the AMA's House of Delegates seemed to have settled the debate once and for all. Unfortunately, that did not prove to be the case. Six months later, in June of this year, the House of Delegates reversed its position. By a close margin, the delegates approved a new resolution introduced by the New Jersey delegation that declared self-referral to be ethical as long as the patient is fully informed about the physician's financial interest in the facility. Although the vote could not change the council's report, which remains part of the AMA's code of ethics, this sudden about-face reveals the confusion and the conflicting interests that still prevent many physicians from recognizing their professional obligations.

The justification offered for the new resolution was unconvincing. Proponents argued that the policy recommended by the council would limit the access of many patients to necessary health services. They also claimed that the great majority of self-referring physicians, who do not abuse their patients' trust, were being penalized because of concern over the few who did. One delegate from New Jersey was quoted in the press as saying, "Sanctions should be applied [to "overutilizers"] when appropriate. . . . But must we always punish the innocent along with the guilty?"[8]

These arguments are transparently spurious. As already noted, the council's report allows for self-referral if the facility is clearly needed by the community and could not be built without physician-investors. As for distinguishing between physicians who abuse self-referral and those who do not, there would be no way to do that without prohibitively expensive and intrusive surveillance of the private practices of all physicians who practice self-referral. Besides, the argument that self-referring physicians should be trusted unless they can be proved to have abused that trust misses an essential point about fiduciary responsibility: people in important positions of trust should not put themselves in situations that inevitably raise questions about their motives and priorities, regardless of whether they actually behave in accordance with that trust.

Physicians are trusted to act as medical purchasing agents for their patients. A doctor who thinks there should be no concern about self-referral as long as it is disclosed and the referrals are monitored is analogous to a purchasing agent for a large corporation who discloses to the chief executive officer (CEO) that he has a vested interest in certain vendors with whom he does business, and who thinks that this disclosure, plus careful surveillance of his purchases by management, should assuage the CEO's concerns. Obviously, it would not do so. In fact, the CEO would probably fire the purchasing agent on the spot. Why should physicians want to apply a lower standard of fiduciary responsibility to themselves than is generally accepted in business?

Two articles in this issue of the *Journal* add to the growing body of evidence that self-referral leads to the overuse of services and excessive cost.[9,10] In a study of free-standing radiation-therapy facilities in Florida, where at least 40 percent of all practicing physicians are involved in some kind of self-referral,[11] Mitchell and Sunshine[9] report that none of the joint-venture facilities were located in inner-city neighborhoods or rural areas, thus refuting the suggestion that joint ventures often bring needed services to otherwise underserved communities. These authors also found that self-referral in radiation therapy, as already reported for other services, was associated with increased use and costs.[9] The second study, by Swedlow et al.,[10] reports on self-referral to three different kinds of outside services in California's workers' compensation system. They found that self-referral increased the rate of use and the cost per case of physiotherapy and increased the cost per case of psychiatric evaluation. Even more interesting, they report that the inappropriate use of magnetic resonance imaging was more frequent among the patients cared for by self-referring physicians, although there was no difference in the cost per case. None of this new evidence is particularly surprising, but taken together with the results of earlier studies cited in the council report, it convincingly demonstrates that self-referral adds to the cost of medical care.

No wonder that government has begun to take restrictive action. In September 1991 the U.S. Department of Health and Human Services issued so-called safe-harbor regulations, which allow physicians to refer Medicare and Medicaid patients to facilities in which they have a financial interest only under limited conditions.[12] These regulations are new interpretations of a Medicare and Medicaid anti-kickback statute that has been on the books since 1972, but they may soon become moot as a result of new, more comprehensive laws at the federal and state levels. A law passed by Congress in 1989 that took effect this year bans the referral of Medicare and Medicaid patients to clinical laboratories owned by their physicians. There is discussion about extending the ban to other kinds of facilities, a move favored by the Bush administration as a means of restraining Medicare expenses. The Internal Revenue Service, reversing its previous stance, has announced that not-for-profit hospitals may lose their tax-exempt status if they enter into certain types of financial arrangements with physicians, including those that involve self-referral. The Federal Trade Commission, which had formerly en-

4. Iglehart JK. The debate over physician ownership of health care facilities. N Engl J Med 1989;321:198-204.
5. Relman AS. Dealing with conflicts of interest. N Engl J Med 1985;313:749-51.
6. Waldholz M, Bogusich W. Warm bodies: doctor-owned labs earn lavish profits in a captive market. Wall Street Journal. February 27, 1989:A1.
7. Pear R, Eckholm E. When healers are entrepreneurs: a debate over costs and ethics. New York Times. June 2, 1991:A1, A17.
8. Iglehart JK. Congress moves to regulate self-referral and physicians' ownership of clinical laboratories. N Engl J Med 1990;322:1682-7.
9. Rosenfeld RH. Market forces set off skyrocketing interest in hospital-doctor joint ventures. Modern Healthcare. May 1, 1984:14:60-4.
10. Physicians and entrepreneurism in health care. In: Gray BH, ed. For-profit enterprise in health care. Washington D.C.: National Academy Press. 1986: 151-70.
11. Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice — a comparison of self-referring and radiologist-referring physicians. N Engl J Med 1990;323:1604-8.
12. Schroeder SA, Showstack JA. Financial incentives to perform medical procedures and laboratory tests: illustrative models of office practice. Med Care 1978;16:289-98.
13. Hennessey D, Killen A, Cashman SB, Parks CL, Bicknell WJ. Physicians' responses to financial incentives: evidence from a for-profit ambulatory care center. N Engl J Med 1990;322:1059-63.
14. Epstein AM, Begg CB, McNeil BJ. The use of ambulatory testing in prepaid and fee-for-service group practices: relation to perceived profitability. N Engl J Med 1986;314:1089-94.
15. Manning WG, Leibowitz A, Goldberg GA, Rogers WH, Newhouse JP. A controlled trial of the effect of a prepaid group practice on use of services. N Engl J Med 1984;310:1505-10.
16. Mitchell JM, Scott E. Joint ventures among health care providers in Florida. Vol. 2. Contract report for the Florida Health Care Cost Containment Board, September 1991. Tallahassee: State of Florida, 1991.
17. Sunshine JH, Bansal S. Operational, professional, and business characteristics of radiology groups in the United States. Radiology 1992;183:535-40.
18. Kramer S, Diamond JJ. The patterns of care study in clinical radiation therapy — a retrospective assessment of quality of care. Stat Med 1984;3: 353-7.
19. Hanks GE, Kramer S. Quality assurance in radiation therapy: clinical and physical Aspects: consensus of best current management the starting point for clinical quality assessment. Int J Radiat Oncol Biol Phys 1984;10:Suppl 1:87-97.
20. Kramer S. The patterns of clinical care in radiation therapy in the United States. Int J Radiat Oncol Biol Phys 1984;10:Suppl 1:49-53.
21. Fuchs VR. The supply of surgeons and the demand for operations. J Hum Resour 1978;13:Suppl:35-56.
22. Wilensky GR, Rossiter LF. The relative importance of physician-induced demand in the demand for medical care. Milbank Mem Fund Q Health Soc 1983;61:252-77.
23. Physicians' current procedural terminology. Chicago: American Medical Association. 1990.
24. Medicare program: fee schedule for radiologist services. Fed Regist 1989; 54(40):8894-9023.
25. Ries LAG, Hankey BF, Miller BA, Hartman AM, Edwards BK. Cancer statistics review 1973-1978. Bethesda, Md.: National Cancer Institute, 1991. (NIH publication no. 91-2789.)
26. Morrison D, Henkle R. The significance test controversy. Boleste, Tex.: Aldin Publishing, 1970.
27. Schwade JG. Supplemental material to testimony on joint ventures in radiation therapy presented to the Subcommittee on Health and Oversight, Committee on Ways and Means, U.S. House of Representatives, October 17, 1991.
28. Council on Ethical and Judicial Affairs, American Medical Association. Conflicts of interest: physician ownership of medical facilities. JAMA 1992; 267:2366-9.
29. The President's Comprehensive Health Reform Program. Washington, D.C.: The White House, 1992:68.

IMAGES IN CLINICAL MEDICINE

Images in Clinical Medicine, a new *Journal* feature, presents a variety of clinically important visual images, emphasizing those a doctor might encounter in an average day at the office, the emergency ward, or the hospital. If you have an original unpublished, high-quality color or black-and-white photograph of a typical image that you would like considered for publication, send it with a brief descriptive legend to Kim Eagle, M.D., Massachusetts General Hospital, Cardiac Unit, ACC 4, 15 Parkman St., Boston, MA 02114. Two 5-by-7-inch prints should be sent. If you submit a slide, please send a 5-by-7-inch print along with it. No more than two persons will receive credit for submitting an image.

13
3-16-93
SB 347

dorsed self-referral as enhancing competitiveness, now thinks the practice may be anticompetitive because it tends to limit the referring physician's choice to the facility in which he or she has invested, and because it keeps prices up. There has also been much activity at the state level. Florida and New Jersey recently banned most self-referrals, and several other states, including California and New York, are considering similar legislation. Thus, it seems evident that still more legislative restrictions are in the offing.

Those who say that ethics cannot and should not be legislated[13] are right, but for government the issue is clearly economic, not ethical. Voluntary ethical guidelines, although essential for the morale of the profession and for its public image and self-image, cannot establish firm national policy. That requires legislation. Some medical organizations oppose legislation because they fear the indiscriminate banning of referrals to all facilities with which the referring physician has any financial connection — even when the arrangement is in the interest of patients and necessary for good medical practice. This concern is legitimate, but the problem can easily be solved if professional groups work constructively with government to develop laws and regulations that are appropriate. Attempts simply to obstruct corrective legislation are, in my opinion, ill advised. They merely strengthen the public's impression that physicians are more interested in pursuing their own economic interests than in preserving their good name or helping to keep costs down. In any case, as recent history has shown, most efforts to prevent legislative action are likely to fail, leaving a residue of public cynicism and ill will toward organized medicine.

The AMA is worried about the erosion of professionalism in a system of medical care that is becoming increasingly commercialized, and its concern is justified. The reputation of medicine as a trusted profession is at stake, as is the profession's own view of its basic values. The AMA has wisely chosen to make the promulgation and enforcement of ethical standards a major strategic goal. It has sought help from state and local organizations in this task and has asked the Federal Trade Commission to allow physicians more flexibility in self-regulation. These initiatives deserve support, but there is still much more to be done in the profession's struggle against commercialization. In addition to self-referral, the AMA should look closely at the sale of drugs by office-based physicians,[14] deals between physicians and the manufacturers of devices and prostheses, and a wide variety of other kinds of joint ventures between physicians and the facilities in which they treat their patients.[5]

It would be a major victory for professional values if the AMA could once again endorse a simple precept that stood as one of the beacons of its pre-1980s ethical code: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."[15] In today's chaotic medical market, doctors need a few clear guidelines. This is one of the best.

It is hard to predict what our health care system will look like in the year 2000, or what the conditions of medical practice will be. What seems clear, however, is that physicians will have little opportunity to help shape the future if they do not retain their public credibility. That is the real importance of the self-referral debate. If physicians choose to act from self-interest, or even if they merely put themselves in positions that suggest self-interest, they risk damaging their most precious possessions — the trust and respect of their patients and the esteem of the general public.

Harvard Medical School
Boston, MA 02115

ARNOLD S. RELMAN

REFERENCES

1. Relman AS. What market values are doing to medicine. Atlantic Monthly. March 1992:99-106.
2. Council on Ethical and Judicial Affairs, American Medical Association. Conflicts of interest: physician ownership of medical facilities. JAMA 1992; 267:2366-9.
3. Relman AS. The new medical-industrial complex. N Engl J Med 1980;303: 963-70.
4. *Idem*. The future of medical practice. Health Aff (Millwood) 1983;2(2):5-19.
5. *Idem*. Dealing with conflicts of interest. N Engl J Med 1985;313:749-51.
6. *Idem*. The health care industry: where is it taking us? N Engl J Med 1991; 325:854-9.
7. Gray BH, ed. For-profit enterprise in health care. Washington, D.C.: National Academy Press, 1986:161-5.
8. AMA eases ethics policy on 'self-referrals.' Boston Globe. June 24, 1992: 10.
9. Mitchell JM, Sunshine JH. Consequences of physicians' ownership of health care facilities — joint ventures in radiation therapy. N Engl J Med 1992;327:1497-501.
10. Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. N Engl J Med 1992;327:1502-6.
11. Mitchell JM, Scott E. New evidence of the prevalence and scope of physician joint ventures. JAMA 1992;268:80-4.
12. Crane TS. The problem of physician self-referral under the Medicare and Medicaid antikickback statute: the *Hanlester Network* case and the safe harbor regulation. JAMA 1992;268:85-91.
13. Todd JS. Must the law assure ethical behavior? JAMA 1992;268:98.
14. Relman AS. Doctors and the dispensing of drugs. N Engl J Med 1987;317: 311-2.
15. Judicial Council opinions and reports. Chicago: American Medical Association. 1969:VII.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 13 cont.
DATE 2-16-93
BILL NO. SB 347

The Washington Post

AN INDEPENDENT NEWSPAPER

Doctors' Self-Referral

SHOULD DOCTORS invest in for-profit treatment facilities to which they send their own patients? The practice is known as self-referral, and doctors are deeply divided over it. The American Medical Association is debating it hotly in its current meeting in Nashville. It sets up an obvious conflict of interest, opponents argue, and they cite the statistical studies indicating that patients get more tests and more therapy when their doctors have a direct monetary stake in the labs and clinics doing the work. But, defenders reply, if they disclose their investment to their patients, that takes care of the ethical issue. Competition holds down costs, they add, and why should doctors be denied opportunities open to other businessmen?

That's exactly the point. Do doctors want to be regarded as successful businessmen or as something quite different? Treating a serious illness requires difficult judgments, and most patients would doubtless like to think that their doctors approach those choices as more than commercial decisions.

A patient should not be required to take into account the physicians' concern for the profitability of their investments. The AMA's Council on Ethical and Judicial Affairs had it right a year ago when it concluded that the practice of self-referral should be presumed inconsistent with a doctor's duty to the patient, except in the rare case in which a community would otherwise lack an important service.

That advice set off a great uproar that culminated last June in the AMA's House of Delegates, which declared self-referral to be ethical as long as the patient is informed of the doctor's stake. But that didn't end the matter. This week the delegates are debating it again. They now have an opportunity to reverse their unwise June decision and put the country's largest medical organization in the much stronger moral position that its own council recommended.

This dispute, along with the uneasiness it must inevitably generate among patients, is a useful warning regarding national health care reform. Relying heavily on commercial competition to discipline medical practice and hold down costs is a questionable strategy with unattractive side effects. As this country approaches the process of reorganizing health care and the means of financing it, one prominent concept calls for an emphasis on managed competition. While there is certainly a place for competition in the future health system, it will have to be tightly managed indeed, and highly regulated, to prevent precisely the kinds of ethical doubts and ambiguities that arise in self-referral.

AMA Decrees 'Self-Referral' Is Unethical

Decision Not Binding On Group's Physicians

By Dana Priest
Washington Post Staff Writer

NASHVILLE, Dec. 8—The American Medical Association today declared it unethical for a physician to refer patients to medical facilities in which the doctor has a financial interest.

In voting on the controversial practice known as "self-referral," the AMA delegates reversed the position they took last year. At that time, the group revolted against a prior decision by the AMA's Council on Ethical and Judicial Affairs that deemed self-referral unethical except in special circumstances.

But today, a strong majority of the AMA's 436-member House of Delegates at the organization's semiannual meeting voted to support the council. Before the voice vote, many members stated their desire to appear "squeaky clean" before a public that has grown critical of the amount of money doctors make.

Describing the debate over self-referral as "lacerating and divisive," AMA chairman Raymond Scalettar said the House of Delegate's decision today has "sent a message that we will always put the interest of the patient before us."

The decision is not legally binding on the AMA's 300,000 members, but carries significant moral weight.

AMA state and county associations are now instructed to help their members divest themselves of involvement in diagnostic labora-

Doctors Urged to End Financial Interest In Facilities Where They Refer Patients

AMA, From A1

tories and other facilities in which they have a financial interest but where they do not actually provide medical care for people.

An exception is providing such facilities in underserved areas where there is a need and physicians may be the only ones with the money and inclination to provide them.

Opponents of the council's decision argued that doctors could avoid the appearance of impropriety by disclosing their financial interest to patients they refer to such facilities. They said declaring the situation unethical unfairly tarnishes the entire profession because of the unscrupulous actions of a few.

The AMA says that about 7 percent of the 600,000 physicians in this country own medical facilities to which they refer patients, but others say the number is as high as 10 percent. The ethics policy approved today applies only to physicians who do not actually provide medical services at the doctor-owned facilities but only refer patients there.

In other action today, the delegates voted to prohibit AMA's leadership from negotiating with the incoming Clinton administration over the possibility of price controls on health care.

Summing up an apparently widespread desire for a firm AMA stance against price controls of any kind, Dick Van Eldik, a Florida delegate, said his colleagues "don't want the AMA to negotiate from a position of weakness. They want a line drawn in the sand."

Among other measures considered today, the House of Delegates

board that Clinton might establish to devise and implement various health reform proposals, "except global budgets, expenditure targets or payment determination."

Price controls are expected to be one of the most hotly contested issues in the coming reform debate

The AMA's decision on physician self-referral "sent a message that we will always put the interest of the patient before us."

—AMA chairman Raymond Scalettar

over how to bring down escalating health care costs.

The AMA's position is counter to an announcement last week by the leadership of the largest commercial insurance group, the Health Insurance Assocation of America, suggesting that the physicians' organization support some form of price controls.

The AMA's strategy, according to many physicians here, will be to enter any negotiations with a set of items on which the group will not compromise, rather than opening up all areas for discussion.

The AMA, like other health industry blocs, has been sharply divided over health reform, and leaders here called repeatedly for unity. "We must have a single voice,"

Sunday. "If we don't unify behi basic policy, it will confuse the p lic. It will put the whole profes in a difficult position with the administration."

But the details and tenor of delegates' votes on health care form frustrated some members, said foreclosing debate on cer topics will create the impression physicians are an obstacle to chan

"Ideas such as a national he care budget is not going to be the table just because the AM opposed to it," said Howard Shapiro, public policy directo the American College of Physici "It sends the message that AMA knows what it opposes, has not yet come up with anyt that contains strong cost contro

The AMA's House of Delegate body elected by state medical a ciations and societies of physi specialists, threw its qualified port behind other proposals Clint believed to favor.

The delegates expressed appr of "managed competition," a m favored by Clinton, as long as it not give unfair advantages to aged care, in which a group of sicians works for a corporate e that scrutinizes and manages the sicians' care of patients. Many h experts believe that the health consumers would purchase in a aged competition system w evolve into "super-HMOs," and t would be hard for physicians in or group practice to compete fo tients.

Many doctors here also expre a desire to change the antitrust so that physicians would be allo to band together to negotiate with insurers or with hospitals

Exhibit #14

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 14
DATE 2/16/93
BILL NO. SB 347

SB 347--Testimony

My name is Jerome Connolly. I am a physical therapist residing in Billings. I am founder and co-owner of First Physical Therapy which is an independent, physical therapist-owned private business employing 24 people and providing services to a wide variety of clientele a portion of which is injured workers in Red Lodge, Laurel and Billings.

First physical Therapy has a 17 + year history of providing effective, low cost, high quality work injury management services. Moreover, FPT is currently working with companies on early return-to-work (ERTW) programs involving the use of the sportsmedicine model in treatment of injured workers or "industrial athletes." Furthermore, has provided effective work injury prevention services to over 50 companies mostly in Montana but also in six other states. The industries served include mining, oil refining, railroad, energy companies, distributors, trucking, manufacturing, hospitality and several small businesses.

I, personally, have been actively involved over the past 13 months through the Billings area Chamber of Commerce and the Coalition for Work Comp System Improvement (CWCSI) in seeking meaningful changes for Montana's worker's compensation system. Changes that will result in a fair and equitable system for employers, workers and providers. Unfortunately, without substantial changes, I cannot support SB 347.

The collective action the 53rd legislature takes in order to be meaningful reform must produce a healthier climate for businesses while creating a fair and sound system for workers' compensation insurance. One with reasonable benefits and premiums and one that is administered effectively and efficiently. One that is fair to the injured worker, the employer and the health provider involved in the care of these individuals. Unfortunately, heretofore, one cannot say that such is the system that has been in existence.

An effective system must have the following elements:

- An emphasis on early return-to-work;
- Safety incentives and mandates;
- Curbing of abuses;
- Prompt payment of healthcare providers on a reasonable fee schedule.

SB 347 represents some good steps in the right direction and provides the basis for a managed care system that will enable the insurer to limit access to, and expenditures for, health care for injured workers. One of its more progressive features is Section 13 which prohibits physician self-referral.

While SB 347 is a good strong stride in the right direction, there are several areas that need to be strengthened or added in order for this legislation to accomplish the reform intended.

A. To instill an early return-to-work (ERTW) philosophy among the employers as well as workers, the creation of a temporary partial disability classification is necessary. This encourages employers to bring workers back to work before they are 100%. Resistance in this area is one of the most frequently encountered obstacles by health providers. The Coalition for Work Comp System Improvement (CWCSI) recommended this in its deliberations and the proposed language I have submitted to you in an amendments packet.

B. Also from the CWCSI reports, an amendment is needed to create a new section to enable a recognized health care provider to treat an injured worker up to twelve times before referral to a Managed Care Organization (MCO) is required. This change facilitates early intervention that is consistent with the rapid response or what can be termed the "sportsmedicine approach" to treating the injured worker and facilitating early return-to-work.

Our practice is currently working with companies to do just that; setting up rapid response and early intervention protocols to avoid lengthy time-loss conditions. An amendment of this type is a key provision of meaningful reform to allow this type of rapid response to take place. It facilitates care that can prevent a long term disability and instead make it a short term problem.

This would also necessitate a change in Section 1, page 2, line 5 adding "physical therapist".

C. In Section 10 a new subsection is needed that allows an injured worker to elect to receive a health service from a provider of choice *IF* the provider is willing to provide the same service as the MCO for an equal or lower cost.

In addition to those new sections, several clarifying amendments are in order to make this reform meaningful.

1. The definition of maximum healing and medical stability requires clarification. Medical stability and maximum healing are not synonymous terms. Medical stability describes a condition that is controlled, or out of danger; a situation in which the condition is not changing or fluctuating. A patient can be medically stable, for example, when transferred out of intensive care.

Maximum medical healing means being restored to maximum health; freedom from physical disease; reached maximum physical potential; all parts functioning normally.

References: Dorland's and Webster's Medical Dictionaries.

These two terms should be divided as some things are appropriate to be decided following medical stability has been reached but others are not. For example, an evaluation of an injured worker's impairment should be conducted after maximum healing; not after mere stability has been reached. To evaluate after only medically stable would result in findings of considerably more impairment than is necessary and that would be determined after maximum physical potential has been accomplished.

Medical stability can be reached with primary medical treatment; maximum healing usually is not. This is consistent with the definition of primary medical services found in Section 2 (21) page 7.

Clarification of this issue can best be accomplished by deleting in Section 2 (14) (page 5) the term "medical stability" and from line 2 page 6 the term "primary".
A new subsection should then be created defining medical stability as a situation in which the condition is controlled, or the patient is out of danger.

It is appropriate to note that physical therapy can contribute to reaching medical stability especially in early return-to-work (ERTW) programs. To be effective, ERTW must involve early intervention. Using the "sportsmedicine" model, rapid response can stabilize the condition by controlling swelling, resolving the pain/spasm cycle and introducing early mobilization which the medical literature supports as the most effective methodology in treating injury. In order to be effective in this regard, SB 347 must include physical therapy as part of primary care. Please insert "physical therapy" after "nursing" on page 8, line 1, Section 2 (21).

2. It is not appropriate to determine permanent partial disability only after "primary" treatment. Nor is it appropriate or desirable to determine permanent total disability only after "primary" treatment. See pages 5,6,7, Section 2 (14) (18) (19) (21)

3. Physical restoration, physical conditioning, and exercise are integral to, and key components of, attaining maximal healing and are, therefore, part of primary medical services. Please strike these terms from page 8, line 9, Section 2 (25).

4. On page 10, Section 3 (1) (b), lines 22-25 should be deleted. While cost-effectiveness studies would be desirable for any medical service, they are based on outcomes assessment and are among the most sophisticated, costly, time-consuming and difficult to perform of all clinical research. In these type of longitudinal studies it is most important to control or account for multiple variables. This subsection specifically mentions return-to-work. The variables in this regard would include a job that is no longer available or an employer who will not allow a worker to return until s/he is 100%.

This subsection gives the insurer an excuse to deny services in the absence of data that may not be available, may be affected by extenuating circumstances, or the insurer simply may not believe, understand or be willing to accept.

More importantly, this subsection mentions nothing of the injured worker who continues to work.

5. The term "Rehabilitative" should be inserted before "palliative" on page 11, line 19 and page 12, line 3. Section 3 (f) and (g). Injured workers who can be kept working by rehabilitative means are successes for the system. This is also consistent with early return-to-work. (ERTW).

6. The legislative intent is not clear relative to how PPOs are to be established and utilized vis a vis the Managed Care organizations (MCOs).

EXHIBIT 14
DATE 2-16-93
SB 347

7. In Section 10 Managed Care Organizations..."or an entity with a managed care organization" is a term that is not qualified nor defined. Does this allow another insurer (e.g., Blue Cross/Blue Shield) to become "a health care provider to become certified to provide managed care"? The phrase "or an entity with a managed care organization" should be deleted in three places.

8. The criteria for application and certification as a MCO is quite extensive and is likely to be quite bureaucratic and costly. In spite of the extensiveness of criteria stipulated in the bill, the process is still quite ambiguous. For example, "satisfactory evidence of the ability to comply with any financial requirements..." if interpreted to be an annual or periodic audit could be quite prohibitive. Even for smaller entities, audits start at around $10,000 and escalate from there.

These MCO criteria have been lifted from the Oregon law and have little if any applicability in Montana. Managed Care Organizations are not applicable to rural (most of) Montana and exclude single service providers which are lower cost providers.

Furthermore, it is not understood how MCOs in the Billings area might interface with the surrounding rural areas. For example, if an injured worker in Red Lodge sees a primary care physician, will the injured worker be required to drive 120 miles round trip to Billings to receive laboratory, x-ray, physical therapy or other health services from the MCO if the primary care physician orders any of those services?

9. Page 24, line 8, Section 11 (3): After "providers", Insert "the employer". The employer is in need of pertinent information relative to status, employability etc., in order to make reasonable accommodation and structure any temporary transitional duty positions or make any return-to-work offers. Since the employer is financially responsible for premiums and modification factors that influence premiums, it is only appropriate that the employer be included in the list of entities to which information should be provided.

10. Another physician in Billings has recently started a "captive" physical therapy practice in his office. Section 13, while a good step, does not preclude this practice of self-referral nor does it allow the insurer to deny payment for services provided in a self-referral situation of this type. Section 13, page 25, line 20, needs amending to cover these kinds of situations.

I have attached a complete list of proposed amendments designed to strengthen SB 347 and make it more equitable. In doing so, these changes continue to pursue the original spirit of the legislation which is to achieve cost-containment, promote early return-to-work and foster fair competition among providers, while maintaining just an element of patient freedom of choice that is consistent with the above.

Please oppose SB 347 as written. I ask you to make the changes as offered in our amendments packet so we all can support this legislation.

Very truly yours,

JEROME B. CONNOLLY, PT
3116 Boulder #8
Billings, MT 59102

Attachments

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 14
DATE 2/16/93
BILL NO. SB 347

SB 347

Questions

The following is a list of suggested questions that legislators may wish to have answered relative to some of the more specific provisions of SB347 and some of the actual effects of those provisions.

1. In Section 10 Managed Care Organizations...the phrase: "or an entity with a managed care organization" is a term that is not qualified nor defined. Does this allow another insurer (e.g., Blue Cross/Blue Shield) to become "a health care provider to become certified to provide managed care"? I suspect it does.

2. What is meant by primary medical services provider? Is physical therapy included? Page 7, line 21.

3. How is it envisioned that PPOs and MCOs will interface. If a physician is required to either be in an MCO or refer to an MCO what benefit is there for a provider to become a PPO?

4. Extensive criteria are listed for MCOs and statutory authority is given the department to establish more rules to certify MCOs. Yet very little is stipulated relative to PPOs. What certification process, if any, is envisioned?

5. SB347 prohibits an injured worker from going directly to a specialist including orthopedists, rheumatologists, podiatrists, etc. If an injured worker has a back or knee condition for which s/he has seen a specialist, wouldn't it make sense to allow that patient to return to that physician rather than go through the "middle man" and incur additional costs?

6. What in this bill as written provides incentive for the employer to take injured workers back to work?

7. This bill appears to discourage or even prohibit injured workers from obtaining treatment from private sector health care providers. Since private practitioners are usually lower cost providers and many have dedicated their resources to becoming efficient work injury management providers, why would we want prohibit or discourage the use of their services?

Re: Managed Care

The Oregon Model

What reason does the public have to believe that this managed care system proposed in SB 347 will save money and reduce premium?

Oregon is using almost an identical system. In fact, much of SB 347 was lifted from Oregon law.

On December 17th an Oregon Lobbyist who was instrumental in the Oregon legislative changes, presented at the meeting of MT's Coalition for Work Comp System Improvement (CWCSI) and described problems Oregon is having with managed care.

He stated:

> There is needless duplication between providers and employers;
> No way to serve rural areas;
> It did solve our chiropractor problem;
> Hasn't saved any money;
> Overall, it's been a big disappointment.

He summarized by saying: "I would advise you to look at what Oregon did in regard to managed care and don't do it that way."

On January 15th the head of the critical claims division of the SAIF (the Oregon entity comparable to our SCMIF) testified before the House select subcommittee chaired by Rep Chase Hibbard. She indicated they had no MCOs in rural or eastern Oregon. In fact, they only had two MCOs in the entire state and they were both in heavily urbanized areas. She advised that we not take a law from another state and try to make it work in ours. "You have to find out what works for your situation; each one is unique and characteristically different."

The managed care system proposed in SB 347 doesn't work for Montana. There are too many problems and unanswered questions.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 14
DATE 2/16/93
BILL NO. SB 347

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

1. Page 2, line 5, Section 1, after: "optometrist" insert: "licensed physical therapist".

*2. Page 5, line 24, Section 2 (14) strike "medical stability".

*3. Page 6, line 2, Section 2 (14), strike "primary".

*4. Page 6, line 3, Section 2 (14) A new subsection should be created to read: "medical stability means a situation in which the condition is controlled, or the patient is out of danger."

5. Page 8, line 1, Section 2 (21), after: "nursing", insert "physical therapy".

6. Page 8, line 19, Section 2 (25): Strike "physical restoration, physical conditioning, or exercise program".

7. Page 10, lines 22 through 25, Section 3 (1) (b): Strike lines 22-25.

8. Page 11, line 19, Section 3 (f), after "stability", insert "rehabilitative".

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

9. Page 12, line 2, Section 3 (g), after "that", insert "rehabilitative,".

10. Page 17, line 20, Section 6, insert new subsection (3) and re-number:
"(3) A medical service provider who is not a member of a managed care organization and who is not:
(a) qualified to be an attending physician may provide services to the injured worker for 30 days from the date of injury or for 12 visits, whichever occurs first, without the authorization of an attending physician. thereafter, medical services provided to an injured worker without the written authorization of the insurer in not compensable; or
(b) an attending physician cannot authorize payment of temporary total compensation benefits as provided in 39-71-701. Except as provided in 39-71-711, only the attending physician at the time of medical stability may make findings regarding the worker's impairment for the purpose of evaluating disability pursuant to 39-71-703.
(Reference: CWCSI Report of the Medical Committee adopted 12/17/92)

11. Page 20, line 8, Section 10 (1), strike: "or an entity with a managed care organization".

12. Page 21, line 21, Section 10 (4), strike "or an entity with a managed care organization".

EXHIBIT 14
DATE 2-16-93
SB 347

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

13. Page 23, line 15, Section 10 (5), strike "or an entity with a managed care organization".

14. Page 20, line 5, Section 9: Insert New subsection (2). "(2) Workers who are subject to managed care are allowed to elect to receive a health service ordered by the attending physician, from a provider of choice if the elected provider is willing to provide the same service as the managed care organization at an equal or lower cost."

15. Page 24, line 8, Section 11 (3), after: "providers", insert: "the employer".

16. Page 25, line 20, Section 13, Strike and replace with: "A treating physician may not refer an injured worker to a health care practitioner or a health care facility in which the referring physician has a financial interest, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer is not liable for charges incurred in violation of this section.

17. Page 8, line 22, Section 2, insert new subsection (26) and renumber:
(26) "Temporary partial disability" means a condition that results when a worker is medically approved to return to the same, a modified or an alternative employment position that the worker is able and qualified to perform prior to reaching maximum healing, and suffers an actual wage loss as a result of a temporary work restriction.

Proposed Amendments--SB 347

(Submitted by Jerome Connolly on behalf of the Montana Chapter of the American Physical Therapy Association)

18. NEW SECTION

(1) If an injured worker is medically approved to return to the same, a modified or an alternative employment position that the worker is able and qualified to perform prior to reaching maximum healing, and suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial compensation.

(2) Weekly compensation benefits for temporary partial disability shall be the difference between the injured worker's hourly wage received at the time of injury, subject to a maximum of forty (40) hours per week, and the actual weekly wages earned during the period for which the claimant is temporarily partially disabled.

(3) Temporary partial disability compensation shall be limited to a total of twenty-six (26) weeks of combined biweekly compensation, or the worker is no longer temporarily partially disabled, whichever occurs first.

(4) The amount of temporary partial disability will be based upon payroll records provided by the employer and calculated on a biweekly basis. The combined wages and compensation benefits shall not exceed the worker's average weekly wage at the time of injury.

(5) Temporary partial disability shall not be considered an element of permanent partial disability, and may not be credited against any permanent impairment, permanent partial disability award, or settlement achieved after the injured worker reaches a point of maximum medical healing.

(Reference: CWCSI Report of the Law Committee adopted 12/17/92)

---

* ***NOTE:*** If Proposed Amendment #5 above is accomplished and "physical therapy" is inserted into primary medical services, (page 8, line 1,), amendments # 2, 3, and 4 are then not necessary.

Exhibit # 15

Montana Trial Lawyers ASSOCIATION

Directors:
Wade Dahood
Director Emeritus
Monte D. Beck
Thomas J. Beers
Michael D. Cok
Michael W. Cotter
Karl J. Englund
Robert S. Fain, Jr.
Victor R. Halverson, Jr.
Gene R. Jarussi
Peter M. Meloy
John M. Morrison
Gregory S. Munro
David R. Paoli
Paul M. Warren
Michael E. Wheat

Executive Office
#1 Last Chance Gulch
Helena, Montana 59601
Tel: 443-3124

Officers:
Thomas J. Beers
President
Monte D. Beck
President-Elect
Gregory S. Munro
Vice President
Michael E. Wheat
Secretary-Treasurer
William A. Rossbach
Governor
Paul M. Warren
Governor

February 16, 1993

Sen. Tom Towe, Chair
Senate Labor and Employment Relations Committee
Room 413/415, State Capitol
Helena, MT 59620

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 15
DATE 2/16/93
BILL NO. SB 347

RE: SB 347

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to portions of SB 347, which revises workers compensation law regarding medical benefits. MTLA opposes numerous provisions of SB 347:

1. The bill reflects an underlying assumption that current law guarantees excessive medical benefits to injured workers. That assumption is incorrect. Current law may indeed provide medical benefits to injured workers inefficiently, and MTLA supports efforts to reduce wasteful and duplicative medical services. But instead of repairing problems, SB 347 amputates them with provisions that:

* deny injured workers treatment for pain (i.e., Section 2, page 7, lines 23-25; page 8, lines 15-21; Section 3, page 11, beginning with line 17);
* deny injured workers maintenance care (Section 3, page 11, beginning with line 17);
* deny injured workers domiciliary care (Section 12, pages 24-26); and
* require injured workers to pay for medical treatments (i.e., Section 3, page 14, lines 8-23) without regard to their ability to pay and even when those treatments are ordered by a doctor unilaterally selected by the insurer (i.e., Section 6, pages 17-18).

2. The bill reflects an underlying assumption that workers compensation insurers are trustworthy and deserve virtually unlimited discretion while injured workers and their medical providers use their discretion to exploit the system. For example:

* Section 11 (pages 23-24) authorizes an insurer to terminate any compensation benefits, not just when an injured worker in fact unreasonably refuses to cooperate but also whenever the insurer believes that the worker has unreasonably refused to cooperate.

* Section 12 (pages 24-25) drastically limits the situations in which an insurer must provide domiciliary care and even then requires such care, not from the date when the claimant needs it but from the date when the insurer knows, by a "preponderance of credible medical evidence" and "with a reasonable degree of particularity," that the claimant needs it.

* Section 13 (pages 25-26) declares that insurers are not liable for charges by self-referring medical providers, but it neglects to extend that admittedly reasonable protection to injured workers.

Thank you for considering these comments. If I can provide additional information or assistance, please contact me.

Respectfully,

Russell B. Hill
Executive Director

Exhibit #17

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 16
DATE 2/16/93
BILL NO. SB 347

TESTIMONY
SENATE BILL 347
Submitted by:
The Montana State Pharmaceutical Association
February 16, 1993

It is acknowledged by all that some type of reform in the provision of medical services within the worker's compensation system is needed. While Montana's pharmacists are willing to live with the fee provisions in this bill, which move the structure to "usual and customary" to Average Wholesale Price plus $5.50 for dispensing, we have two large problems with this bill as it is written. They are:

1) The bill has left broad rulemaking authority up to the Department of Labor, and because definitions of "preferred provider" are extremely vague, we could quickly move towards a system of "sole provider." What does this mean to Montana's pharmacists and the pharmacies that provide all Montanans with much needed services? It means that insurers could exclude all but one provider in a given area, and that area may be very large. An example may be that there would be one pharmacy chosen in Billings, to the exclusion of all others, one pharmacy in Libby to the exclusion of others. Another example would be that no rural pharmacies would receive a contract, and that injured workers would have to obtain their pharmaceutical products from a facility located a long ways away from where they live. An absolutely worst case scenario is that insurers would contract with large out-of-state pharmaceutical "warehouses" known as mail order pharmacies, and force the injured worker to get their drugs by mail. Because Section 1 of the bill exempts comp insurers from the Freedom of Choice Act, the problems I have outlined are not just possible, but highly probably. However, we concede that this legislature may have a willingness to exempt workers compensation from the Act, and therefore ask that you adopt amendments to this bill that will rectify potential problems. They are:

a) Section 5, page 16, line 3
Following: "limitations"
Insert: New subsection (1) "Any pharmacy in Montana which agrees to provide such services, products, and prices as designated by the department or the insurer shall be allowed to participate as a preferred provider under the definitions of this legislation. No insurer shall disallow any pharmacy from participating as a preferred provider for any reason whatsoever except that they cannot comply with provisions of preferred provider agreements. In addition, no pharmacy shall be disallowed from participating in any managed care organization.

b) Section 5, page 16
Following: New subsection (1)
Insert: New subsection (2) "An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out of state mail service

pharmacy as defined in Title 37-7-702 without affording the opportunity to obtain the same medications from a pharmacy in this state with no financial penalty to the injured worker."

Renumber: Following subsections

2) In the bill, on page 16, new subsection (5), line 22, pharmacy reimbursement rates have been changed from usual and customary to a fee schedule which is Average Wholesale Price of the product plus a $5.50 dispensing fee. While we are willing to live with the AWP plus a dispensing fee, we believe that to put the fee in statute means that it may stay at that rate for years. We suggest language that will index this fee, so that legislative time will not be wasted with future bills that do nothing but ask for an increase in the fee. We propose the following amendment:

a) Section 5, page 17, line 1

Following: Product

Insert: "The foregoing limitations on dispensing fees shall be multiplied by the inflation factor as defined in 15-30-101 (8) for the year; the resulting figure shall be rounded off to the nearest $.10 increment."

Exhibit #17

BOZEMAN PHYSICAL THERAPY CENTER

300 NORTH WILLSON, SUITE 703G
BOZEMAN, MONTANA 59715

406-587-4501 PHONE
406-587-3919 FAX

Improving human performance, function, and quality of life

- Evaluation
- Treatment
- Consultation
- Prevention
- Research
- Rehabilitation
- Education
- Aquatic Program
- Pediatrics
- Movement Analysis & Force Plate Studies
- Functional Capacity Evaluations
- Job Site Analysis
- Pre-placement Screening
- ADA Compliance

SERVICES FOR:

- acute injuries
- chronic pain
- sports injuries
- work injury rehabilitation
- orthopedic conditions
- neurological conditions

TO: Senate Labor and Employment Relations Committee

FROM: Gary Lusin, MS, ATC, PT

RE: Senate Bill 347

DATE: February 15, 1993

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 17
DATE 2/16/93
BILL NO. SB 347

It is with some reluctance and personal conflict that I must oppose portions of this bill. For the sake of brevity I will comment only on portions that I have concerns or questions on. Over the last four to six years the records will reflect that I, as well as my professional association, have been willing and vocal participants in promoting positive change within the Worker's Compensation System. My intentions continue to be forthright and certainly within the spirit that all of us have to rectify the many problems within the Worker's Compensation System at this time.

SECTION I

I request that the Committee seriously consider including licensed physical therapists under the Freedom of Choice Act. If true Worker's Compensation reform is one of the goals of this legislature the provision for allowing injured workers to see physical therapists directly must be viewed as the initial phase of early return to work. I personally have raised this concept before to the Subcommittee on Early Return to Work, Rehabilitation, and Benefits in the fall of 1992 as well as in discussions with State Fund officials and other Legislators. My experience is that debate on this issue is worthless unless key individuals will seriously listen to our proposal and the benefits it can provide injured workers as well as the Worker's Compensation System.

Nine states currently allow this provision in their Worker's Compensation Law, two of which are Idaho and South Dakota. In this state citizens of Montana have legally been allowed to see a physical therapist without a physician referral since 1987. To my knowledge no complaints or problems have arisen from this provision and it has resulted in savings to insurers and patients.

I am not advocating that injured workers see physical therapists without the medical attention of a physician. I am suggesting that the law appropriately allow physical therapists, as skilled rehabilitation professionals for acute and chronic injuries, to provide early treatment to injured workers when those injuries fall within the scope of physical therapy practice. Rules and guidelines can easily be written to allow injured workers to receive the services of a physical therapist directly, while at the same time scheduling to see their physician, and through the course the initial goals of treatment are to return the injured worker to work as soon as possible and as the injury allows.

I am only requesting that the physical therapists be able to present this concept logically to the Committee or appropriate individuals without the inclusion of outside individuals who have unfounded biases towards this concept. The Legislature, if allowed to decide this issue on their own, may be pleasantly surprised at the benefit licensed physical therapists can provide to the Worker's Compensation System but more importantly to injured workers and their employers.

SECTION 2 (14)

The definitions of "medical stability", "maximum healing", or "maximum medical healing" are vague and may need further definition.

As the physical therapist I see many people who, at least by my understanding of these definitions, are actually medically stable or their injury may be healed, however, their functional status may be the major problem. I am curious if it would be necessary to include the term, along with definition, of <u>functional stability</u> since this may have a relation to language later in the bill under the definitions of permanent partial and permanent total disability with regard to determining the injured worker's physical capability of returning to work.

Many times it is not so much the medical healing that is of question but the functional abilities and deficits a person is left with once the healing has been completed. It may be helpful to have a distinction between maximum medical healing and its relation to maximum functional healing (or a like term).

SECTION 2 (21), (25)

The new language which is included to define "primary medical services" and "secondary medical services" are of considerable concern to me as a physical therapist. It does not state under primary medical services that physical therapy is included although there is historical evidence that we have been included under the medical language in previous laws as well as rules and regulations.

EXHIBIT 17
DATE 2-16-93
SB 347

The items listed under secondary medical services really encompass a large majority of what physical therapy has to offer. Specifically this involves physical restoration, physical conditioning, or exercise programs or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities. Also included is the term work hardening and it is my opinion that perhaps work hardening is appropriately placed in secondary medical services.

However, since so much of the hands on, education, and advise that is involved in rehabilitating an injured worker is covered under language in secondary medical services, I would appreciate clarification as to exactly where physical therapy would fall? Are we to assume we are covered under primary medical services and if so are the exercise programs and physical rehabilitation techniques excluded from primary medical services? If the latter is true what this language does is promote modality based treatment which is simply hot packs, ultrasound, massage, electrical stimulation, and ice which have only a relatively small place in true work injury rehabilitation.

I would appreciate clarification as to where physical therapy as it is currently legally practiced fits in to the definitions of primary medical services versus secondary medical services.

The ramification of these two paragraphs, at least as I read them, can have a profound and significant impact on my physical therapy practice should it be determined that physical therapy is a secondary medical service. My practice currently has approximately 45% of its patient load being injured workers. All of these workers have been referred to us by physicians and I have no control over the types of patients physicians refer to me. Should my services be deemed secondary medical services, and this bill goes through as it is written, it literally puts me, as well as my colleagues, in a situation where insurers could restrict any or all injured workers from being referred to or treated in my practice. I sincerely hope it is not the intent of this legislation to put my business, as well as many other businesses, in jeopardy and that it would be recognized that my practice as well as many other practices are providing an excellent and cost effective service to injured workers and we should be actively sought out to continue that service.

Accurate and valid clarification of this language would be helpful.

SECTION 3 (1), (B)

This language appears to be directly related to work hardening and work conditioning programs or possibly other services that are construed to be very expensive and of long duration. The message behind this language appears very short sighted. While conceptually I agree with this language, in reality this should not be the concern of medical care providers.

What this language is saying is that if an injured worker is injured, and the vast majority of them are legitimally injured, and for some reason they do not have a job to go to then full and appropriate medical treatment is not worth paying for simply because they do not have a job to go to.

This language creates a significant dilemma for injured workers in that it apparently will be determined how much medical care they will receive and to what level of function they will be returned to solely based on whether or not they have a job to return to.

I support some level of demonstration of the cost effectiveness of services in returning an injured worker to an appropriate level of function but whether or not that person actually has a job to return to should not dictate how much medical service he or she is to be provided, nor if the program is effective.

If the intent of this particular section is to limit the use of work hardening and work conditioning programs, then it needs to be done based on other parameters than return to actual employment. This is actually an area where physical therapists can be of significant help in not only clarifying the language but providing objective documentation as to a person's functional ability and limitations and could also identify when the person is at a level of function to return to some form of employment. Once they are ready treatment could be terminated. Judging cost effectiveness of these types of programs solely on the fact that the worker actually return to employment is totally unfair to the effectiveness of these programs. This is much more related to the current job situation in Montana and I would almost guarantee that if jobs were available and individuals had them to return to then the cost effectiveness of these programs could be easily demonstrated.

SECTION 3 (7)

In the defense of injured workers I have seen many workers who were injured on minimum wage jobs and who essentially fall into the classification of the "working poor". Having them pay medical providers, $10.00 each visit, may be a significant burden to many legitimally injured workers and their families. I fully support the concept of having injured workers pay for some of their care but I would ask the Committee to evaluate this particular language to see if it truly is in the best interest of the injured worker and their family. There have been many injured workers who it has taken weeks or months for them to get their wage loss checks or even travel checks from State Fund so they can make appointments and provide basic services to them and their families.

I am assuming it would be the responsibility of the medical service provider to collect this money including taking the patient to court or turning them over to a collection agency in the likely event that

they would not pay for these services. Another option would be that medical service providers would require payment in advance on the day of service to see that money is collected. This may influence compliance with treatment.

SECTION 13

I fully support the concept of this language and commend the Committee for including it. There is significant data regarding physician self referral within physical therapy most recently out of California and Florida. The data is compelling that there is an increased cost when treatment is provided in a physician's office or in a facility in which the physician owns the service. Utilization is the primary variable that is increased.

Several states have enacted legislation to prohibit any type of physician self referral for physical therapy services. The AMA currently finds the practice unethical except when it is in an area that does not have access to other services.

I would encourage the Committee to include in this language that physicians may not refer a claimant to a health care facility, including the physician's office practice, particularly in areas where there are already these services being provided.

CONCLUSION

The sections I did not comment on are generally acceptable to me and I will await further clarification regarding the managed care and preferred provider language as that continues to develop.

I hope some of my questions and concerns can be clarified or addressed and I look forward to those responses.

EXHIBIT 17
DATE 2-16-93
SB 347

AFLCIO

Amendments to Senate Bill No. 347
First Reading Copy

Requested by Senator [redacted] Towe
For the Senate Committee on Labor and Employee Relations

Prepared by Eddye McClure
February 19, 1993

1. Page 10, lines 22 through 25.
Following: line 22
Strike: subsection (b) in its entirety
Renumber: subsequent subsections

2. Page 11, lines 9 and 10.
Following: "~~department~~"
Strike: remainder of line 9 through "insurer" on line 10

3. Page 14, lines 8 through 23.
Strike: subsection (7) in its entirety

4. Page 17, line 11.
Following: "subsection"
Strike: "(3)"
Insert: "(4)"

5. Page 17, line 14.
Following: line 13
Insert: "(2) An injured worker who is determined to be in need of a referral to managed care may choose a system from any of the managed care systems that have been certifed by the department. Subsequent referrals must be approved by the insurer. A dispute between the claimant and the insurer regarding subsequent referrals must be resolved through the mediation process provided by the department."
Renumber: subsequent subsections

6. Page 17, line 23.
Following: "the"
Strike: "insurer"
Insert: "department"

7. Page 18, line 9.
Following: "subsection"
Strike: "(3)"
Insert: "(4)"

8. Page 18, line 11.
Following: "the"
Strike: "insurer"
Insert: "department"

8. Page 19, line 8.
Following: "providers."
Insert: "This section does not prohibit the worker from choosing the initial treating physician under [section 6(1)]."

9. Page 23, line 9.
Following: first "practitioner,"
Strike: "or"
Following: second "practitioner"
Insert: ", or a chiropractor"

10. Page 24, line 4.
Following: "organization"
Insert: "or treating physician"

11. Page 26, line 2.
Following: "insurer"
Insert: "or the claimant"

12. Page 26, line 17.
Following: line 16
Insert: "(3) The department may seek recommendations for representatives from the state licensing boards governing the providers."

SUBCOMMITTEE

Amendments to Senate Bill No. 347
First Reading Copy

Requested by SB 347 Subcommittee
For the Senate Committee on Labor and Employee Relations

Prepared by Eddye McClure
February 19, 1993

1. Page 5, line 9.
Following: line 8
Insert: "(10) "Disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment. Disability does not mean a purely medical condition."
Renumber: subsequent subsections

2. Page 7, line 23.
Following: "treatment"
Insert: "prescribed by a treating physician"

3. Page 7, line 25 through page 8, line 2.
Following: "stability."
Strike: remainder of line 25 through "medicine." on page 8, line 2

4. Page 8, lines 19 and 20.
Strike: line 19 through "programs" on line 20
Insert: "physical restoration programs and other restoration programs designed to address disability and not impairment,"

5. Page 14, line 24.
Following: line 23
Insert: "(d) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is an examination requested by an insurer pursuant to 39-71-605."

6. Page 17, line 9.
Following: line 8
Insert: "(9) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy."

7. Page 18, lines 24 and 25.
Following: "with" on line 24
Strike: "physicians or physician groups or"
Following: "pharmacies," on line 25
Strike: "physical therapists,"

treating physician on the grounds that the worker is making demonstrable progress toward recovery. A treating physician shall document this progress in terms of the utilization treatment and standards established in 39-71-704(2). A request by a worker must be considered approved by the insurer unless, within 10 days of receiving the request, the insurer produces countervailing opinion evidence that demonstrable progress toward recovery has not been shown. The workers' compensation court shall establish an informal procedure for the speedy resolution of disputes arising under this subsection. An insurer may petition the court for an order to the worker to show cause why the worker should not report to managed care, and a worker may petition the court for an order to the insurer to show cause why the insurer should not continue to reimburse the worker's treating physician for services rendered to the worker. If a preponderance of the evidence shows that the worker is making demonstrable progress toward recovery, the insurer may not limit the worker to treatment from a managed care organization if the worker elects to continue treatment with the treating physician selected by the worker."

Renumber: subsequent subsection

10. Page 13, line 6.
Strike: "14"
Insert: "13"

11. Page 16, line 23.
Strike: "7"
Insert: "6"

12. Page 18, line 12.
Strike: "9"
Insert: "8"

13. Page 19, line 14.
Strike: "6"
Insert: "5"

14. Page 19, line 17.
Page 20, line 1.
Strike: "10"
Insert: "9

15. Page 26, lines 18 and 20.
Strike: "14"
Insert: "13"

CHIROPRACTORS

Amendments to Senate Bill No. 347
First Reading Copy

Requested by Senator Blaylock

For the Senate Committee on Labor and Employee Relations

Prepared by Eddye McClure
February 20, 1993

1. Title, lines 9 and 10.
Strike: "REVISING" on line 9 through ";" on line 10

2. Title, line 17.
Strike: "39-71-711,"

3. Page 1, line 19.
Insert: "STATEMENT OF INTENT
A statement of intent is required for this bill because 39-71-704 (1)(g) and (1)(h) authorizes the department of labor and industry to adopt rules for the appointment of physician panels to review proposals for palliative or maintenance care and, upon the advice of professional licensing boards of practitioners, to exclude from compensability any medical treatment found unscientific, unproved, outmoded, or experimental."

4. Page 4, line 23 through page 5, line 4.
Strike: subsection (7) in its entirety
Renumber: subsequent subsections

5. Page 9, line 21.
Strike: "(29)(a)"
Insert: "(28)(a)"

6. Page 12, line 13..
Following: "appropriateness."
Insert: "The rules must provide that the panel include at least one physician from the same profession or practice area as the treating physician."

7. Page 14, line 24 through page 15, line 25.
Strike: section 4 in its entirety
Renumber: subsequent sections

8. Page 17, lines 24 and 25.
Following: "for" on line 24
Strike: line 24 through "duration" on line 25
Insert: "15 working days"

9. Page 18, line 8.
Following: line 7
Insert: "(4) Notwithstanding the provisions of subsections (3)(a) through (3)(d), an injured worker may also request the insurer to authorize continued treatment by the worker's

Amendments to Senate Bill No. 347
First Reading Copy

Requested by Senator Wilson
For the Senate Committee on Labor and Employee Relations

February 20, 1993

1. Page 4, line 23 through page 5, line 4.
Strike: subsection 7 in its entirety
Renumber: subsequent subsections

2. Page 12, line 11.
Following: "physicians,"
Insert: "that shall include at least one treating physician from the area of specialty in which the injured worker is being treated,"

3. Page 12, lines 21 through 23.
Following: "services" on line 21
Strike: remainder of line 21 through "are" on line 23

4. Page 13, line 10.
Following: "rates"
Strike: "must"
Insert: "may"

5. Page 13, line 11.
Following: "."
Insert: "The rates established by the Department pursuant to this subsection shall be not less than medicaid reimbursement rates."

6. Page 13, line 14.
Following: "responsibilities."
Insert: "For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana."

7. Page 14, line 24 through page 15, line 25.
Strike: Section 4 in its entirety
Renumber: subsequent sections

8. Page 19.
Following: line 21
Insert: "A worker who is subject to managed care may choose from managed care organizations in their community that have a contract with the insurer responsible for the worker's medical services."

Exhibit #8

MISSOULA PHYSICAL THERAPY CENTER

Professional Village, Suite 6
715 Kensington, Missoula, Montana 59801
406-543-4890

RICHARD L. SMITH, M.S., P.T.

EDIE G. SMITH, P.T.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 18
DATE 2/16/93
BILL NO. SB 347

SENATE BILL 347
TESTIMONY

My name is Richard Smith. I am here representing the Montana Chapter of American Physical Therapy Task Force on Workers Compensation, and myself as a Physical Therapist and Occupational Health Consultant in independent private practice. I have been a therapist for 17 years and for the past 6 years, I have practiced in Missoula where, along with my wife, we have provided rehabilitation, education, and injury prevention services to hundreds of injured workers and employers. Approximately 50% of our business is Workers Compensation related.

I serve on both Montana and national American Physical Therapy Association Task Forces working to solve Workers Compensation problems that deal with physical therapy. I train therapists around the country and have published papers on progressive work rehabilitation. I tell you this only to show that I have a broad experience working in the system.

I have been told my practice does a good job, that I do a good job, when it comes to providing evaluation and rehabilitation services, which fall under this medical bill SB347. I pride myself in the fact that I am independent of any conflicts of interest; I am not owned by, employed by, or controlled by anyone. I receive no kickbacks. I don't split fees with anyone.

SENATE LABOR & EMPLOYMENT
EXHIBIT NO.
DATE
BILL NO.

I don't lease my equipment or space from referral sources. I receive my referrals from a wide range of sources and try to promote the highest quality of care, generate the most accurate and object data possible, to facilitate early return to work of injured workers.

This would all change under Senate Bill 347. Injured workers would have limited access to my services. Private practice physical therapists cannot provide primary medical services, other than physical therapy, if physical therapy is even included in the definition. You will say I could contract with a managed care organization. Think about that scenario. I understand that large medical clinics and hospitals are ready to become MCO's. Montana's two largest medical clinics have their own physical therapy clinics. Do you think they are going to use private practice physical therapists?

Whether managed care is mandatory or optional, therapists will be at the mercy of the MCO for referrals. The injured worker has little, if any choice, except to go into the managed care system. I compare it to the difference between shopping at large, big-business shopping malls versus your local, small business shop. Where do you get more personal service? Better service? Does quality matter? I ask you, where would you rather shop? If you were injured, where would you prefer to be rehabilitated? Ask the insurers, doctors, employers and injured workers where the

quality of care and best rehabilitation work is done in this state.

The way to decrease costs and increase quality of care is to increase competition, not form monopolies.

I support parts of this bill. For example, Section 13 addresses referral for profit. This is a step in the right direction, but only a small step. Please strengthen or clarify the language to outlaw all referral for profit situations. Physicians and MCO's should not be allowed to refer to physical therapy clinics in which they have a financial investment. The Mercer Work Comp study showed self-referral in California generated $223 million in physical therapy services delivered for economic rather than clinical reasons. (Copy of study attached) If you need stronger language or research documentation of the excessive costs associated with referral for profit, please contact me.

I welcome peer review, utilization review and treatment standards as described in Section 10, Subsection 4c. But I will see workers only when they are referred by the MCO, according to Subsection 4f. I suspect the MCO will use my services as a last resort, if at all. For the first time, I would be forced to align myself, "choose sides", if you will, with specific and limited referral sources. I will be forced to work for the MCO.

EXHIBIT 18
DATE 2-16-93
SB 347

If the purpose of SB 347 is to contain costs, then consider the following: Strong utilization guidelines (pomolgated by Dept of Labor and Industry) may be all we need to add to the current system to deny compensation for unreasonable and unnecessary medical services.

I understand the crisis we face very well. The goal in this bill seems to be to allow the insurer to control the management of claims using a narrow and limited doctor-based MCO.

Theoretically, managed care can work in Montana. But will it? It has not been tried in rural areas. A month ago, here in Helena, we heard from 3 national experts, Gary Anderberg from Conservco, Michelle Graham, from the SAIF Corp., and Brian Rassmussen, from the APTA. All three of them urged caution and flexibility to pick and choose. Perhaps a two year prospective trial of managed care is in order. Prospective studies are controlled research studies to answer specific questions - - in this case, is a managed care system more or less effective than what we currently have?

This bill restricts access to critically needed Independent Physical Therapy and Rehabilitation Services. I support aggressive case management, early intervention, and early return to work. Physical therapists want to be part of the solution to the current crisis, and I believe we can be effective in helping,

if given the opportunity.

Thank you for the opportunity to provide my input.

Respectively submitted,

Richard L. Smith, MS, PT

SUGGESTED LANGUAGE CHANGES

I support Definition 13, "Maintenance Care", but this language can be stronger. I suggest that if treatment is not rehabilitative, and if there is no documentation of improvement, then treatment can be considered maintenance.

Under Section 3, Subsection 2, establishing a fee schedule for hospitals is financially responsible. However, this language is unclear whether the hospital fee schedule will be the same or different from the non-hospital service fee schedule.

I recommend omitting Definition 21, "primary medical services", and Definition 25, "secondary medical services." These definitions discourage, if not preclude the claimant from receiving physical therapy rehabilitation services. Moreover, the definitions are unnecessary overkill because the Department

of Labor and Industry is promogating service rules that will specifically regulate utilization of physical medicine and rehabilitation services. These two terms are used in other sections, such as 3a and 3b where the vagueness of "for those periods as the nature of the injury or the process of recovery requires" and "clear demonstration of cost effectiveness" is very subjective. In the place of these definitions, I recommend language strengthening Section 3, Subsections 3f and 3g, that maintenance care if not compensable. Furthermore, I would recommend under 3g, that matters related to physical therapy be reviewed by physical therapists instead of physicians.

Under Section 3, Subsection 7, the $10 co-payment will not work. The client will simply refuse to pay and walk out.

RLS:slb R:Bill 347.ltr

Exhibit # 19

MONTANA CHAPTER
OF THE
AMERICAN PHYSICAL THERAPY ASSOCIATION

February 14, 1993

To: Senator Tom Towe and Members of the Senate Committee on Labor and Employment Relations

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 19
DATE 2/16/93
BILL NO. SB 347

Re: Senate Bill 347

Dear Senator Towe and Members of the Committee,

I am contacting you regarding this bill due to my grave concern with several sections. Please to not construe from this that I am opposed to cost containment and that I do not think that there are several sections of this bill which I favor.

The most serious of these sections are Section 6 and 8. These two sections will put my clinic out of business along with the other private practice physical therapists in this state. Literally this will put hundreds of people out of work. These will be higher paying jobs which will be forced to leave the state that presently has a shortage of Physical therapists. There is no provision which will allow referral to the private physical therapy provider and it will be impossible for us to join a managed care organization (MCO) as the organizations which can now qualify by being able to provide "all primary medical services" have in their employ physical therapists. Mind you that many private practicing therapists have taken specialized training in treating the injured worker and now provide these services for a less expensive cost that the organizations that may qualify. Therefore you are eliminating the most effective and efficient providers from the system. For clarity sake I have outlined the sections with comments below.

Section 1. Physical Therapists should be included in this section along with the other providers.

Section 2.(14) Medical stability does not mean the same thing as maximum healing. A person could be just out of intensive care and be medically stable but not maximally healed.

Section 2 (21) This must include all physical therapy functions many of which are shifted into Secondary Medical services such as exercise programs, work hardening, physical restoration, and physical conditioning. These activities are critical to restoration of function as well as early return to work.

Section 2 (25) The items of work hardening, physical restoration, physical conditioning, or exercise programs needs to be included in section 2 (21). This includes many of the higher level programs for treatment of the injured worker. To have this out encourages the use of modality based treatments to be done in Primary medical services.

Section 3 (a) What is or will be the definition of "reasonable" primary medical services?

Section 3 (1)(b) There is no mention of maintaining a workers abilities for their employment to keep them on the job in this section, only returning to actual employment is included.

Section 3 (2) This is an excellent section needed for a long time. We have been trying to assist the State Fund and the Department of Labor in setting utilization guidelines for several years.

Section 3 (7)(c) excludes chiropractors who are not treating physicians and does not include all other providers such as ot's. I have had patients who could not have afforded to come in after a work injury if they would have had to pay $10 per visit.

Section 6 This section as I read it would mandate that a worker could choose his physician but if that physician wished to refer to any other medical provider the referral must go to the managed care organization and it also indicates that the insurer has the right to switch the worker to the MCO. Later in the rules in section 10 it indicates that to be an MCO one must have a treating physician, and provide primary and secondary medical services. This would eliminate private pt's from applying and therefore eliminate them unless they could join a MCO but this is highly unlikely or impossible as the MCO's will be hospitals and larger medical clinics who have their own pt departments.

Section 8 Without knowing the criteria now we do not know what a managed care organization will be or become.

Section 10 This section eliminates a private pt unless they have a physician with them who can be a treating physician and only if they can provide all the necessary primary and secondary medical services. No private pt's meet this criteria in this state. This would put many who have even a moderate workers comp. case load OUT OF BUSINESS taking them off the tax rolls and loosing many jobs in the state.

Section (10)(d) pays lip service to early return to work but does not put the emphasis where it belongs and does not provide incentives for employers to get injured workers back early.

Section (10)(f) specifies that a physician who is not in the MCO must refer to the MCO if specialized treatment is needed and then singles out physical therapy. Many of the private practice pt's are specialists in treating the injured workers and provide that service now cheaper than other treating facilities. This looks like a reduction in access to cost effective and the highest quality providers and will require injured workers out of the largest cities to travel to the MCO's which are going to be available only in larger areas. To my knowledge this has not worked in any other rural state. In addition, travel for many injuries has a dramatically negative effect on healing.

Section 13 This is basically a good section but needs to be tightened to eliminate referral by physicians who employ a physical therapist in their office.

COMMENTS IN GENERAL

We have heard from two individuals within the workers compensation system in Oregon from which similar language exists and both have cautioned against MCO in rural settings. They indicate they have used them only in their largest metropolitan areas which are much larger than our largest two cities combined. They simply do not serve the injured workers in rural areas of this state.

With constructive changes to these sections the physical therapists in the state could perhaps support this legislation following review of the changes. We would be more than willing to help with this task in any way. Please do not hesitate to contact me if we can help.

Sincerely,

Lorin R. Wright

Lorin R. Wright,PT
P.O. Box 341
Red Lodge, Mt. 59068
446-1112

EXHIBIT 19
2-16-93
SB 347

Exhibit #20

114 First Avenue West
P.O. Box 2768
Kalispell, Montana 59901
406-756-6782
406-755-6782 FAX

NORTHERN ROCKIES
THERAPY CENTER, INC.

Ann Lawson PT
Clinical Director
Don Bestwick PT, ATC
Laura Wyman PT
Kenny Klundt MT
Anita Lavin PT

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 20
DATE 2/16/93
BILL NO. SB 347

February 16, 1993

Sen Tom Towe Labor & Empl. Relations
Chr. Comm. on ~~Business and Industry~~
Capital Building
Helena, MT 59460

Sen. Towe and Committeemembers:

I am writing in opposition to Senate Bill 347 as it is currently written. Having spent considerable time reviewing this bill, I find that it has several areas that need clarification and refinement. In addition, I wish to be perfectly clear that I strongly agree that Montana Worker's Compensation systems needs drastic reform.

I will make specific reference to several areas of this bill that I feel need alteration:
In Section 2 paragraph 25 which is headed "Secondary medical services": there is a grouping of both active and passive "services" that clearly do not belong in the same classification. For example, the physical conditioning or exercise that is medically necessary to improve a worker's tolerance enable him/her to return to work, is drastically different than "equipment", or a "hot tub". Following general healing of an injured tissue, conditioning/strengthening exercises are in most cases very necessary to avoid re-injury to that same body part. I strongly protest the inclusion of these items as though they are similar.

InSection 3 paragraph 1b, the "insurer shall furnish secondary medical services only upon..." speaks about clear demonstration of cost-effectiveness of the services. I feel that the intent of this paragraph is good, but I question how it will be reinforced efficiently. I also question how retroactive denial to pay for services already provided, or determining "cost-effectiveness" of treatment in advance of approval can occur! This certainly may create a negative incentive to provide immediate needed followup care to an injured worker when the question of whether it will be reimbursed remains in clear question until the course of treatment is over.

In Section 3 paragraph 1g the procedure outlined here could take 3-4 weeks with the present system of staff and efficiency demonstrated at WC. There is well-documented evidence that the earlier an injured worker can be returned to his workplace, a drastic reduction occurs in the likelihood that he will remain "disabled" and out of the workforce. Paragraph 1g, clearly disallows the chance for timely, immediate care of an acutely injured worker. That same worker could beback on the job productively by the time the WC "procedure" as indicated could give approval to begin treatment. Telephone calls, and response from the WC offices is currently quite slow, much slower than private insurers. This added "burden" to an already overloaded system, certainly can't create better services for the injured worker. I suggest that there be a special category for "traumatic, spinal or musculoskeletal" injuries that could be expedited through the procedure of paragraph 1g in order to avoid delay of unnecessary wait time.

In Section 3 paragraph 7a, I agree with the worker's obligation to provide a co-payment for services in general. However when a worker is completing their conditioning process, they may be seen 3-5 times per week for a 3-6 week period, depending on their specific needs. The cost of co-pay for such an intense

treatment schedule would be burdensome and not possible for most injured workers. I therefore propose that a "special consideration" section be added to cover a reduced co-pay amount for such circumstances.

Section 11 in its entirety is much needed, long overdue and a welcome addition to the WC laws! I offer no suggestions for change here. I also heartily endorse an end to over-utilization of Physical Therapy services as covered in Section 13. I feel that this area alone will cut the cost of WC rehabilitation considerably.

In completion, as an owner of a multi-therapist Physical Therapy clinic in Kalispell, I wish to comment on the impact SB 347 will have on my business. **There is a strong possibility that this bill, as written, will put me out of business.** Care of injured workers represents approximately 60% of my caseload. The impact of this bill as written would have devastating consequences to the ability for us to operate. I implore you as a committee to recognize the excessively stringent measures directed toward Physical Therapy services as a "highlighted" target. I resent this. Workers Compensation is not in the fiscal crisis that it is from just Physical Therapy overutilization.

I challenge you to recognize the professional judgement of licensed, qualified medical professionals in determining what care is appropriate for our worker's and force good documentation of those services. I am deeply dissatisfied with the concept that an insurance claims adjustor is in some way more competent to determine a Physical Therapy plan of care than the professional themself. This is not likely to decrease our disabled workforce, is not proactive, and does not advocate for our injured worker as we should feel charged to do.

Thank you for your consideration of my above comments. I greatly appreciate the hard-working efforts that went into creation of this bill. However, it clearly needs refinement.

Sincerely yours,

Ann L Lawson PT

SENATE LABOR & EMPLOYMENT
EXHIBIT NO 22
DATE 2/16/93
BILL NO SB 347

NAME Terry L. Jackson MD

ADDRESS 69 Sun River Road Great Falls MT.

HOME PHONE 454-3833 WORK PHONE 771-7557

REPRESENTING Self

APPEARING ON WHICH PROPOSAL? SB 347

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 21
DATE 2/16/93
BILL NO. SB 347

FEB 16 '93 11:10AM BEUT P.1

To Tom Towe
Chairman Senate Labor

From Russ Logan Billings Chamber Chair
Workers Compensation committee

Senate Bill 347 (Sen John Harp)

Senate Bill 347 is an accumulation of efforts of many people including the Billings Chamber of Commerce and the Coalition for Work Comp System Improvement

Some of the components of the bill are definitely controversial however if we are going to have improvement- we must have change.

The changes in this bill are good for work comp cost reduction and abuse.

I encourage you to see through the special interests that seek to defeat this bill and make the commitment to future generations of Montanans that we are responsible stewards of Montana's financial affairs

* Please give this bill a favorable recommendation as written.

Pardis Chiropractic Clinic

"Discover Our Gentle Effective Care"

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 23
DATE 2/16/93
BILL NO. SB 347

February 13, 1993

Senator Tom Towe
Capitol Station
Helena, MT 59620

Dear Senator:

My family has been working to provide chiropractic services to people from Montana for over 40 years. Please help us amend senate bill #347 so that injured workers are not denied this safe and effective care.

Sincerely,

James H. Pardis, D.C.

JHP/sw

M—M Enterprises
1054 GRANT DRIVE
SUN PRAIRIE VILLAGE
GREAT FALLS, MONTANA 59401
PHONE 965-2280

MELVIN M. MART

KATHLEEN M. MART

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 24
DATE 2/16/93
BILL NO. SB 347

Dear Senators:

I understand the bill makers of Montana Want to introduce legislation to cut off the use of chiropractic care from the Workers Compensation — this will mean the injured worker in Montana can no longer see a Chiropractor for their injuries the Workers Compensation is in trouble — But cutting off our care will not help the injured worker — Only make it worse.

The injured workers of Montana need more than they are getting they need help from Chiropractors, Doctors, Surgeons and most of all from our Elected Officials —

Thank You

Melvin M. Mart

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 25
DATE 2/16/93
BILL NO. SB 347

Feb 16, 1993

Dear Senators

I am writing to you today in reguards to Workmans Comp. and the decision to possibly bar Certain doctors from Workmans Comp payments especially Chiropriators.

In light of this new issue I feel it necessary to voice my thought on the matter. I Currently suffer from a back injury. I have been to several Medical doctors. Some do not know what to do for my back aside from perscribing drugs and more drugs and pain killers (which in turn play Havoc with my Ulcers). I submitted my self to there treatments but to no avail.

The other half of the of the Medical Profession, and I should emphasize all these are orthopedic doctors (experts in their field).

recommend an expensive surgery with no guarantees that it would help.

While you are off work recuperating, this in turn takes a long recovery time.

Need I say more - this is all very costly and unnecessary for Workman's Comp.

I have found that the Chiropractor I have been going to has helped me the most.

I go for treatments and follow it up with exercise and diet, for the first time since seeing [redacted] a medical Doctor's. I feel as though my back is getting stronger and I'm making real progress thanks to the Chiropractors and at the fraction of the cost. Perhaps it is the Medical-Doctors procedures that should be scrutinized instead of the Chiropractor. Please consider my case when you're making decisions, there are so many more in my situation. Thank you for your time and consideration.

Sincerely Edward J Wright

SENATE LABOR & EMPLOYMENT
EXHIBIT NO. 26
DATE 2/16/93
BILL NO. SB 347

TO WHOM IT MAY CONCERN:

I am writing this letter in regards to Worker's Comp allowing a patient to seek alternative care verses medical care. When my case with Worker's Comp was settled, I was cut off from chiropractic care. The settlement will, however, allow me to continue to see a medical doctor and will pay for any treatment he feels is necessary. His recommendation was for physical therapy and nonsteroidal drugs.

Now I will be the first to admit that I had my doubts about chiropractic care. When it came to either being doped up to relieve pain or chiropractic care, I chose chiropractic care and have not regretted my choice. I have known to many people who have become addicted to prescription drugs. I did not even want to consider this possibility.

I checked into the costs of physical therapy and non-steroidal drugs. The **average** price of physical therapy is $60 to $70 per session. One injection of a nonsteroidal drug is $75. My chiropractic care was $52 per week. I do not see how Worker's Comp, with the financial trouble it is in, can afford to stop people from seeking alternative care. It makes absolutely no sense to pay a medical doctor two to three times the amount when I can get relief from my chiro-practor.

My working hours are from 8:30 a.m. to 5:30 p.m. The hours that physical therapy is available to patients are from 8:30 a.m. to 5:00 p.m. In order for me to go, I would have to take time off from work. This would put my job in jeopardy. I thought the whole purpose of Worker's Comp was to get people back to work and not to cause them to lose their jobs.

These are just some of my concerns about Worker's Comp. I have many more but that would take many more pages. I am now paying for my chiropractic care out of my own pocket. As far as I am concerned, if you do not allow alternative care for Worker's Comp, you are punishing patients for trying to get the help they think is the best and most cost effective for them.

Sincerely,

Penny C. Stevens

DATE 2/16/93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: SB 274, SB 347

page 1 of 3

Name	Representing	Bill No.	Check One Support	Oppose
Dr Wayne E. Jacobsmeyer	Chiropractors	347		X
Dr. L Jan Peterson	Chiropractor	347		X
Dr K. Wanda Tomatis	Chiropractor	347		X
Veronica Brady	St Council HERE	274		X
Barbara Downing	HERE Local 5 6	274		X
M.N. Pardis	Chiropractor	347		X
Dr Bali Larson	chiropractic	347		X
CHARLES BROWN	CHIROPRACTIC	347		X
ADOLF D. HOKLIN	CHIROPRACTIC	347		✓
Don Hecht	Chiropractic	347		
Don Judge	MT STATE AFL-CIO	SB 347 SB 274		X
Beth McLaughlin	HERE	274		X
Beatrice VanDorst	Here	274		X
Evelyn Allen	Here	274		X
Dr. Jim Pardis	Chiropractic	347		X
Dr. Mark Hertenstein	Chiropractic	347		X
Dr Gary E. Jimmerson	Chiropractic	347		X
John Mining		274		

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

E1C

DATE 2/16/93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: SB 274, SB 347

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Cindy Polinsky	Local 1427	274		✓
[illegible]	[illegible]	347	✓	
John A. Guy	St. Peter's Community Hospital	347	✓	
[illegible]		347		✓
James Tutwiler	MT Chamber	347	✓	
Robert Johnson	NFIB	347	X	
Jacqueline Denmark	AIA	347	w/amdts	
[illegible]	Deaconess Med Ctr	347	✓	
Don Allen	CWCST	347	X	
George Wood	Mt Self Insurers Assn	347	✓	
Dick Reel	Gov. Office	347	✓	
Roger Tippy	MT St Pharmaceutical Assn	347		Amd
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	347	✓	
Mary McCue	MT Association of Acupuncture & Oriental Med	347		✓
Leon Stalcup	MT Rest. Assoc	274	✓	
Greg Gould	Pharmacy			✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F1C

DATE 2-16-93

SENATE COMMITTEE ON Labor

BILLS BEING HEARD TODAY: SB 274 SB 347

page 3 of 3

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Jacky Cascione	HERE	274		X
Dr Pamela A Blanchard	Chiropractic	347		X
Robert Olsen	MT Hospital Assoc	347	✓	
Terry Minow	WORK COMP COALITION	347	✓	
Harley Thompson	MBTA + CWCSI	347	✓	
Dr Ronald N Hecht	Chiropractic	347		
Dr Gary L Hall	Chiropractic	347		
Dr John Francis	Chiropractic	347		
Melissa Case	Hotel Employees & Restaurant	274		X
Richard Smith	Physical Therapy Assoc	347		
Charles E. Brooks	MT Retail Assoc	347	✓	
Lorin Wright	phys. Ther. Assn.	347		✓
[illegible]	Phy Therapy Assc	347		✓
Jack A Hays	Teamsters	274		✓
Kevin Kennelly	MT Chapter American Phys. Therapy Assoc	347		✓
Gail Wheatley	Phys. Therapy Assoc	347		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

assigned risks were taken care of by the same plan. Senator Keating answered this was a monopolizing view. He said this could drive up taxes, as the same type of plan had done in Canada.

Closing by Sponsor:

Senator Keating told the Committee the only way to keep a financial exposure to the Montana taxpayer was to privatize workers' compensation. He stated SB 405 provided for the State Plan to be phased out by July 1, 1994. He said this plan would encourage competition. He told the Committee more than 100 thousand Montanans, and 40 million Americans were estimated covered by self-funded plans, or ERISA plans. He continued these had lower premiums of about half the State Plans'. Premiums paid into private plans have generated reserves and the retention of costs are much lower, yet the self-funded plans pay higher benefits than a State Plan.

Senator Keating said Oregon had higher benefits than Montana, and a similar benefit package would be good for Montana. He said the date for getting the State Fund out of Montana could be postponed if the privates wanted to pick up a market share in Montana. He said if they did not, the State Fund would be available to fall back to. He said there would be no competition until the State Plan charged actuarily sound premium rates. He told the Committee as premiums go up employers lay-off employees. Senator Keating said SB 405 had merit, and if the Committee wanted to amend it, he asked the ERISA plan stay within the matrix of the Bill. He asked help in amending it while keeping the potential.

EXECUTIVE ACTION ON SB 347

Motion:

Senator Wilson moved that subcommittee amendments (SB034701.AEM) be adopted.

Discussion:

Senator Keating asked Senator Harp if the chiropractors and physical therapists were able to participate in the providing rehabilitation and services for the recovery of workers. Senator Harp answered they would.

Senator Keating asked Senator Harp if the physical therapists were provided for in the Bill. Senator Harp answered physical therapists were considered "treating physicians" by SB 347.

Vote:

The amendments SB034701.AEM were UNANIMOUSLY ADOPTED, with Senator Lynch voting yes by proxy.

Motion:

Senator Wilson asked that amendments (SB034703.Anb) be reviewed in concept, reserving the right to change any grammatical errors, as the amendments had not been through editing. He moved the amendments be adopted.

Discussion:

Nancy Butler, General Council, State Fund, explained the amendments (SB034703.Anb). Ms. Butler stated item 2 of the amendments was requested by the Chiropractors. She said the next three amendments were in response to concern the hospitals had voiced. She explained item 5 of the amendments would help the Montana Department of Labor and Industry establish rates by giving the department rates to look at.

Senator Towe asked Nancy Butler who would set would the rates mentioned in item 5. She answered the Montana Department of Labor and Industry would set the rates.

Ms. Butler continued to explain item 6, saying that this would allow the insurer to pay only what the insurer would pay for services in Montana, whether or not the person receiving services received the services in the state.

Senator Blaylock asked clarification on item 6. He asked if a person decided to go to an out-of-state care center for medical service, would an insurer pay only what would be the normal rates for the same care in Montana, and the person who sought the care would pay what was not covered by the insurer. Ms. Butler explained it would depend on the hospital's policy. If the hospital billed in excess of insurance coverage, the person seeking care out-of-state would pay the excess.

Ms. Butler said the AFL-CIO had raised a question regarding having more than one Managed Care Organization (MCO) available in a community. Item 8 allows a worker to choose which MCO to receive services from if there is more than one in a community.

Senator Towe asked Nancy Butler if "Managed Care Organization" was a defined term within SB 347. She answered it was defined in section 8, line 9, page 19 of the Bill.

Vote:

The amendments SB034703.Anb were UNANIMOUSLY ADOPTED, with Senator Lynch voting yes by proxy.

Discussion:

Don Judge, Executive Secretary, Montana State AFL-CIO, explained amendments (SB034705.AEM). He said item 2 of the amendments was meant to limit power of the insurer and leaves the Montana Department of Labor and Industry to determine rules that establish when travel needs for health care are legitimate.

Eddye McClure pointed out the amendment in item 2 did not put into words "pursuant to rules adopted by the department," but just eliminated "only if the travel is incurred at the request of the insurer." Mr. Judge said the amendment should reflect "pursuant to rules adopted by the department," and asked the old language be reentered.

Mr. Judge went on to explain item 3 of the amendments proposed striking out subsection (7), the co-payment section.

Senator Towe asked Mr. Judge why he would want to strike subsection (7). Mr. Judge answered there was no other state in the country requiring co-payment.

Mr. Judge explained item 5. He said this amendment would allow the employer to chose a MCO. Mr. Judge told the Committee this provision would allow an employer to chose from health care organizations certified by the Montana Department of Labor and Industry, rather than being forced to seek the services of one that had a contract with the insurer, or not get benefits paid.

Mr. Judge explained items 7, 8, 9, 10, 11, and 12.

Mr. Judge said there was currently no provision in SB 347 regarding an employee's rights to appeal a termination or denial of benefits. In item 13 of the amendments, a provision as such is inserted.

Mr. Judge explained item 14. He said an injured employee's family should be entitled to receive the prevailing wage for the care the family member would have been providing.

Mr. Judge explained item 15. He said the number "8" was an arbitrary decision to cut off benefits at 8 hours, rather than grant benefits for the number of hours of care needed.

Senator Aklestad expressed he had problems with some of the amendments. He asked Senator Harp to respond to the amendments. Senator Harp answered he would rather not amend SB 347 any more.

Senator Towe said the amendments (SB034705.AEM) needed to be looked at individually.

Senator Aklestad asked for a consensus of the Committee. He argued the Bill was being watered down. He said there would be other chances to amend SB 347. Senator Towe answered there were

concerns about the Bill, and the Committee had an obligation to consider the amendments proposed by the AFL-CIO. Senator Aklestad restated he would like to hear the consensus of the Committee members. Senator Blaylock said it would be only fair to the AFL-CIO to look at the amendments one by one. He said they were not all substantive. Senator Wilson said he concurred with Senator Blaylock, and that Senator Lynch would do the same.

Item 1 of amendments (SB034705.AEM) was considered by the Committee. Senator Harp said the amendment had nothing to do with secondary medical care. Senator Towe asked Senator Harp to clarify if the wording of SB 347 provides that if because of an injury, a worker could never return to employment, that worker could not get secondary medical care that would not affect the chances of returning to employment. Senator Harp answered he would not get into individual cases.

Senator Towe asked Don Judge if this was his concern. Mr. Judge answered it was. Senator Harp said he disagreed.

Senator Keating asked if the employer was not receiving benefits for a secondary injury because of the condition of not being able to return to work. Senator Towe answered this was how the Bill read.

Don Judge explained that under current law these people are currently receiving benefits. He continued the section on Page 10, lines 22 through 25 in SB 347 would require the insurer to furnish secondary medical services defined on page 8 of the Bill only upon a clear demonstration of the cost effectiveness in returning the injured worker to employment.

Pete Strizich of the State Fund responded to Mr. Judges concerns. He stated second medical treatment was designed specifically to eliminate revenue enhancement programs among medical service providers. He said primary medical services were provided for in the Bill. He said if an injury related to impairment, the treatment would be a primary service. He said SB 347 was designed to cut out high-cost programs doing nothing to return an injured employee to work.

Senator Towe asked Mr. Strizich if it was his belief the language on the bottom of page 11 covered the situations that were being discussed. Mr. Strizich answered that it was the intent of the language to cover this type of situation.

Senator Towe asked Don Judge to respond. Mr. Judge answered he was concerned that "permanently partial" was not covered, but that "permanently total" was. Senator Towe answered Mr. Judge was correct.

Item 2 of (SB034705.AEM) was discussed. Senator Towe asked what kind of travel other than that at the request of the insurer was there. Mr. Judge answered it depended upon the injured worker.

He said there were already rules set by the Montana Department of Labor and Industry that defined legitimate travel in accordance with what was needed for medical treatments. Mr. Judge said it seemed reasonable to rely on existing rules. Senator Towe asked Senator Harp to respond. Senator Harp said there was nothing that was being offered in amendments (SB034705.AEM) he agreed with.

Senator Blaylock asked Don Judge if he knew how often travel provisions were being abused by the injured employee. Senator Blaylock said the provision was in the bill because there was abuse. Mr. Judge said this was a good point, but there was no way of addressing the cost of fraudulent travel. Senator Harp said in the last biennium was $1.8 million for injured workers to travel from one clinic to another. Senator Harp stated SB 347 was not denying the injured worker needed travel, but the insurer would have the chance to talk to the injured worker to see if the travel meets the insurer's approval under a managed care situation.

Senator Towe asked Senator Harp what would happen if the primary treatment doctor treating a patient deems a certain medical test needed, and the patient needs to travel to receive the test, but the insurance company refuses to pay costs. Senator Harp answered under a managed care system the patient would not go for the test. He continued in an MCO the insurer would have a substantial reason for the travel not to occur. Senator Towe asked why the travel should not be at the request of the MCO, rather than the insurer. Senator Harp answered under SB 347 the person paying the bills, or the insurer, should have some control over how the money was being spent.

Senator Blaylock asked Chuck Hunter, Montana Department of Labor and Industry, if there would be an appeals process under the legislation if the employer was denied travel by the insurer. Mr. Hunter answered there would be a dispute over what the medical benefit was. This would come to a mediation process.

The Committee discussed item 3 of the AFL-CIO amendments. Senator Towe said the theory of the Bill's section in question unamended was after the employee's first visit to a medical care institution, each subsequent visit will cost the employee $10.00, or $25.00 if the visit is to a hospital in an emergency situation. The amendment would strike this section (page 14, lines 8 through 23). Senator Towe explained the theory was there was perhaps over-utilization of medical services, and by requiring the employee to pay some of the cost, some of the over-use would be eliminated. Senator Towe said an argument was this provision in SB 347 may conflict with the Constitution. Senator Keating explained the language in the Constitution said if the employer provided workers' compensation in accordance with state law the employer is not subject to liability. He said the exclusive remedy is providing coverage as provided by state law. Senator Keating said if the section of SB 347 was in state law,

and the employer had bought coverage in accordance to it, there should be no constitutional challenge. Senator Towe noted an argument in court may go either way.

Motion:

Senator Blaylock moved item 3 of amendments (SB034705.AEM) be adopted.

Discussion:

Senator Aklestad spoke against the motion. He said there was only one state that requires employees to pay into the system, that state being Washington. He said this requirement had never been overturned by a court. He noted this was not an exact, but a similar case as to the one proposed in SB 347.

Vote: The Motion FAILED with Senator Aklestad, Senator Keating, Senator Burnett, and Senator Wilson voting NO. Senator Towe and Senator Blaylock voted YES. Senator Lynch voted YES on a proxy vote.

Discussion:

Item 5 of the amendments (SB034705.AEM) was examined. Eddye McClure noted this amendment (item 5 of (SB034705.AEM)) and the already adopted amendment - item 8 of Senator Wilson's amendments (SB034703.Anb) would conflict. Senator Towe said this was correct. He said if this amendment was to be adopted, Senator Wilson's amendment would need to be changed.

Motion:

Senator Blaylock moved items 6 and 8 of amendments (SB034705.AEM) be adopted.

Discussion:

Senator Keating asked why involve the Montana Department of Labor and Industry in such a situation. He said the insurer would be the one selecting the physician. Don Judge said the Montana State AFL-CIO, in proposing this amendment was attempting to avoid an insurer enforcing upon the employee a doctor with which the insurer had a contract. He said because the last amendment (item 5) was not adopted the "company doctor" situation would be in place. Mr. Judge said there was no further reason to consider items 6 and 8.

Motion:

Senator Blaylock withdrew his motion to adopt items 6 and 8, and moved that items 5, 6, and 8 of amendments (SB034705.AEM) be

adopted.

Discussion:

Senator Harp stated SB 347 was not a "company doctor bill". He said the concepts in the Bill had worked in Oregon, and there was no one to be hurt by the provisions. Senator Harp stated SB 347 was the only way to get the system under control.

Senator Towe stated the "company doctor" concern was legitimate, as employers had been hurt by the "company doctor" before. He stated the question was when a person had an initial treating doctor, and was referred, would the same argument apply to the referral. Senator Towe asked Mr. Judge to comment.

Mr. Judge said the managed care system was to be chosen from those MCO's certified by the Montana Department of Labor and Industry. He said the patient still had the choice of staying with the initial treating physician. He said the injured worker should have the right to select from among any number of MCO's certified by the department.

Senator Towe commented there were doctors he would want his clients to go to, and some he would not.

Vote :

The motion by Senator Blaylock that items 5, 6, and 8 of amendments (SB034705.AEM) be Adopted FAILED, with Senator Keating, Senator Burnett, Senator Aklestad, and Senator Wilson voting no. Senator Towe and Senator Blaylock voted YES. Senator Lynch voted yes on a proxy vote.

Discussion:

Item 13 of the amendments (SB034705.AEM) was considered. Senator Towe clarified this amendment would insert an appeal provision. Senator Towe asked if there was any appeal provided for in SB 347 without the amendment. Nancy Butler answered the bill provided for mediation in workers' compensation court, rather than appealing with the Montana Department of Labor and Industry. Mr. Judge said the amendment was put in by request of Senator Lorents Grosfield. He said if there was already an appeals provision in place, that was satisfactory.

Items 14 and 15 of the amendments were considered. Senator Towe said the question of item 14 was whether a family member caring for an injured worker should receive minimum or prevailing wage. Item 15 questioned whether that payment for the care should be limited to 8 hours per day, or the number of hours required to care for the person.

Senator Towe said item 14 was reasonable, as minimum wage was not good policy for the state. He stated item 15 was unreasonable,

as asking to pay for 24 hours per day was too much.

Mr. Judge clarified item 15 was not asking that someone be paid for 24 hours per day. He stated the eight hours provided for in SB 347 was arbitrary, not based upon medical conclusions as to how much care is needed by the individual. He said item 15 would provide pay for the required number of hours of care an injured worker would need. The required number of hours would be a medically determined decision.

Nancy Butler explained the domiciliary care statute. She said the current provision said the insurer was required to pay a family member for 24 hours per day at about $7.50 per hour, or $180.00 per day. Ms. Butler continued this was very expensive for an insurer. She said a nursing home would, on average, cost about $67.15 per day. If the care needed was less then an RN or LPN could provide, but still substantial enough to meet standards in SB 347, a family member could provide that care. The family member would be limited to what it would cost the insurer to provide care for the injured worker in a nursing home. She said the Bill also recognized the fact that care might be required less than 24 hours per day. An RN or LPN would not be paid for more than the hours worked. She said a family member would be limited to 8 hours per day at minimum wage. Ms. Butler explained if the prevailing rate of $7.50 was used, at eight hours, the cost to the insurer would be $56.00 per day. It would cost the insurer only $67.15 for 24 hour care in a nursing home. Ms. Butler said this was not a distinctive difference.

Senator Towe stated he thought the 8 hour provision was not unreasonable, but the minimum wage bothered him.

Senator Wilson said he had never been a proponent of minimum wage for anyone.

Senator Towe suggested the Committee adopt item 14, but not 15.

Senator Burnett said if a family member was taking care of the injured worker, it should be done without cost. Senator Towe said it was not the family member's fault the worker was injured.

Senator Aklestad said it was a hardship on a family member to have care come into the home. He stated that live-in care was not necessarily 24 hours per day, but varied depending upon the care needed.

Senator Keating stated that if someone needed care, and the insurer would put the person in a nursing home, but the family chose to care for the person at home, the family should not be able to charge more than what the insurer would pay for a nursing home. Senator Towe answered this limit was in SB 347.

Senator Harp stated Senator Wilson made a good point, and that he was not an advocate of minimum wage either.

Motion\Vote:

Senator Wilson moved that the Committee adopt item 14 of amendments (SB034705.AEM). The motion to adopt item 14 of amendments (SB034705.AEM) CARRIED UNANIMOUSLY with Senator Lynch voting YES by proxy.

Discussion:

The items 8 and 9 of amendments (SB0347707.AEM) (chiropractors amendments) were discussed by the committee. Bonnie Tippy explained the amendments. She told the Committee language in the amendments would help answer the question of when a person should go into managed care. Ms. Tippy said item 8 reflected the belief an injured worker should not go into managed care until the worker has lost wages for fifteen days. She explained language in item 9 of the amendments said employees making demonstrable progress should not be forced into a managed care organization by an insurer.

Roger Tippy explained he was not a lobbyist for the Chiropractors, but had been asked to draft item 9. He stated after an employee had lost wages for fifteen working days, as provided for in item 8, item 9 would provide for an appeals process to stay out of managed care that would utilize the workers' choice to stay with the treating physician. The initial procedure would grant the insurer 10 days to study the treating physicians documentation and to decide if it matched utilization guidelines. The insurer would then decide if the prognosis by the treating physician was realistic. If the insurer decided it was not realistic, and the employee did not ask the workers' compensation court to utilize speedy equity powers, managed care would begin. An employer could apply with workers' compensation court for a temporary restraining order, or other equivalent court order, then attend a hearing. A judge would set up a hearing without attorneys present, and listen to the employees physician and the insurers physician. The judge could then make the decision whether or not the injured worker should enter managed care.

Senator Towe asked where the chiropractors fit into SB 347, and why they were advancing the issue. Ms. Tippy answered the chiropractors' problem with the Bill was that once a claimant entered an MCO, the MCO run by a medical clinic would have no interest in that injured worker continuing to be treated by a chiropractor. She continued that this interest of not allowing a patient to continue receiving chiropractic treatment was profitable. She exemplified this statement by stating a back surgery done under managed care would be much more profitable then several treatments by a chiropractor.

Senator Harp answered under managed care the first priority was to get the injured worker through the process. He continued,

saying the system of managed care had beliefs contrary to those Ms. Tippy had stated. Senator Harp told the Committee for every day a worker was not in managed care, the worker would not be being treated fairly. The injured worker would not be back to work, and every day cost the State Fund money. He said he did not view managed care as being run strictly by medical doctors. He told the Committee he believed the amendments worked outside the purpose of SB 347.

Senator Blaylock asked Pete Strizich, State Insurance Fund, if he would comment on the amendments. He said the State Fund had looked at the items and believed they defeated the purpose of a managed care system.

Senator Towe asked Pete Strizich how he would respond to the concern about some doctors not referring to a chiropractor, no matter if a chiropractor could be of help. Mr. Strizich said what Ms. Tippy had stated had been an ongoing battle between the chiropractors and the AMA for years.

Mark Staples told the Committee that the intent of the Bill was not to take an injured worker from a treating physician that is accomplishing progress toward getting the worker back to work. He stated the amendment was designed to add language to clarify that point.

Senator Towe asked Mr. Staples if a chiropractor was considered a treating physician in SB 347. Mr. Staples answered a chiropractor was, but an injured worker could be taken from the treating physician after any duration of lost wages. He clarified that wage lost would start after six days.

Senator Harp stated the treating physician was not just a chiropractor, but anyone under the definition in SB 347. He said the Bill was designed to take a worker into managed care as quickly as possible in order to get the person back to work as quickly as possible. He stated there needed to be a truce between the State Fund and the chiropractors. Senator Harp went on to say the Bill allowed for the insurer to leave the patient outside the MCO and with the treating physician. He said the problem was the chiropractors did not have good faith with the State Fund. He continued the insurers had to work with the State Fund to reach a fair compromise. He said the chiropractors were valuable in getting injured employers back to work.

Motion:

Senator Keating moved items 8 and 9 of amendments SB034707.AEM be adopted.

Discussion:

Senator Aklestad stated the amendments had merit, but a statute

was already in the Bill that dealt with the same situation. He said there would be other places to amend SB 347. Senator Aklestad urged the Committee to pass the Bill out of Committee with the amendments already accepted, but not any more.

Vote:

The motion FAILED with Senator Keating voting YES. Senator Lynch voted YES on a proxy vote. Senator Towe, Senator Blaylock, Senator Aklestad, Senator Burnett, and Senator Wilson voted NO.

Motion\Vote:

Senator Aklestad moved SB 347 DO PASS AS AMENDED. The motion carried UNANIMOUSLY.

EXECUTIVE ACTION ON SB 342

Motion\Vote:

Senator Towe moved amendments (SB034201.AEM) be adopted. The Motion to adopt amendments (SB034201.AEM) CARRIED UNANIMOUSLY. Senator Lynch voted YES by proxy.

Discussion:

Senator Keating asked how the amendments adopted would help a private contractor. Senator Towe answered they would clarify that a contractor could not get fringe benefits so high they were above the prevailing wage.

Senator Keating asked if these fringe benefits could be paid into a trust. Senator Towe answered if SB 342 was passed, the contractor could put the benefits into a trust.

Motion\Vote:

Senator Blaylock moved SB 342 DO PASS AS AMENDED. The Motion carried with Senator Towe, Senator Blaylock, Senator Wilson, Senator Aklestad, and Senator Keating voting YES. Senator Lynch voted YES by proxy vote. Senator Burnett voted NO.

EXECUTIVE ACTION ON SB 62

Motion/Vote:

Senator Wilson moved SB 62 be TABLED. The Motion CARRIED, with Senator Towe, Senator Blaylock, and Senator Wilson voting YES. Senator Lynch voted YES on a proxy vote. Senator Burnett, Senator Keating, and Senator Aklestad voted NO.

ROLL CALL

SENATE COMMITTEE Labor & Employment Relations DATE 1/20/93

NAME	PRESENT	ABSENT	EXCUSED
Sen. Towe	X		
Sen. Wilson	X		
Sen. Akkerstad	X		
Sen. Blaylock	X		
Sen. Keating	X		
Sen. Lynch	X		
Sen. Burnett	X		

SENATE STANDING COMMITTEE REPORT

February 22, 1993

MR. PRESIDENT:
We, your committee on Labor and Employment Relations having had under consideration Senate Bill No. 347 (second reading copy -- yellow), respectfully report that Senate Bill No. 347 be amended as follows and as so amended do pass.

Signed: Thomas E. Towe
Senator Thomas E. "Tom" Towe, Chair

That such amendments read:

1. Title, lines 9 and 10.
Strike: "REVISING" on line 9 through ";" on line 10

2. Title, line 17.
Strike: "39-71-711,"

3. Page 4, line 23 through page 5, line 4.
Strike: subsection (7) in its entirety
Renumber: subsequent subsections

4. Page 5, line 9.
Following: line 8
Insert: "(9) "Disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment. Disability does not mean a purely medical condition."
Renumber: subsequent subsections

5. Page 7, line 23.
Following: "treatment"
Insert: "prescribed by a treating physician"

6. Page 7, line 25 through page 8, line 2.
Following: "stability."
Strike: remainder of line 25 through "medicine." on page 8, line 2

7. Page 8, lines 19 and 20.
Strike: line 19 through "programs" on line 20
Insert: "physical restoration programs and other restoration programs designed to address disability and not impairment,"

8. Page 12, line 11.
Following: "physicians,"
Insert: "including at least one treating physician from the area of specialty in which the injured worker is being treated,"

9. Page 12, lines 21 through 23.
Following: "services"
Strike: remainder of line 21 through "are" on line 23

10. Page 13, line 6.
Strike: "14"
Insert: "13"

11. Page 13, line 10.
Following: "rates"
Strike: "must"
Insert: "may"

12. Page 13, line 11.
Following: "groups."
Insert: "The rates established by the department pursuant to this subsection may not be less than medicaid reimbursement rates."

13. Page 13, line 14.
Following: "responsibilities."
Insert: "For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana."

14. Page 14, line 24.
Following: line 23
Insert: "(d) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is an examination requested by an insurer pursuant to 39-71-605."

15. Page 14, line 24 through page 15, line 25.
Strike: section 4 in its entirety
Renumber: subsequent sections

16. Page 16, line 23.
Strike: "7"
Insert: "6"

17. Page 17, line 9.
Following: line 8
Insert: "(9) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy."

18. Page 18, line 12.
Strike: "9"
Insert: "8"

19. Page 18, lines 24 and 25.
Following: "with" on line 24
Strike: "physicians or physician groups or"
Following: "pharmacies," on line 25
Strike: "physical therapists,"

20. Page 19, line 8.
Following: "providers."
Insert: "This section does not prohibit the worker from choosing the initial treating physician under [section 5(1)]."

21. Page 19, line 14.
Strike: "6"
Insert: "5"

22. Page 19, line 17.
Strike: "10"
Insert: "9"

23. Page 19, line 21.
Following: "workers."
Insert: "A worker who is subject to managed care may choose from managed care organizations in the worker's community that have a contract with the insurer responsible for the worker's medical services."

24. Page 20, line 1.
Strike: "10"
Insert: "9"

25. Page 23, line 9.
Following: first "practitioner,"
Strike: "or"
Following: second "practitioner"
Insert: ", or a chiropractor"

26. Page 24, line 4.
Following: "organization"
Insert: "or treating physician"

27. Page 25, line 18.
Following: "prevailing"
Strike: "minimum"

28. Page 26, line 2.
Following: "insurer"
Insert: "or the claimant"

29. Page 26, line 17.
Following: line 16
Insert: "(3) The department may seek recommendations for representatives from the state licensing boards governing the providers."

30. Page 26, lines 18 and 20.
Strike: "14"
Insert: "13"

-END-

ROLL CALL VOTE

SENATE COMMITTEE LABOR ; EMPLOYMENT RELATIONS BILL NO. SB 347

DATE 20 February 1993 TIME 4:05 A.M. (P.M.)

NAME	YES	NO
Sen. Tom Towe	X	
Sen. Bill Wilson		X
Sen. Jim Burnett		X
Sen. J.D. Lynch	X	
Sen. Chet Blaylock	X	
Sen. Tom Keating		X
Sen. Gary Hklestad		X

Kelsey Chapman
SECRETARY

Senator Tom Towe
CHAIR

MOTION: By Sen. Blaylock to adopt Items Three (3) of AFLCIO Amendments (SB034705.AEM).

ROLL CALL VOTE

SENATE COMMITTEE LABOR ; EMPLOYMENT RELATIONS BILL NO. SB 347

DATE 20 February 1993 TIME 4:21 A.M. (P.M.)

NAME	YES	NO
Sen. Tom Towe	X	
Sen. Bill Wilson		X
Sen. Jim Burnett		X
Sen. J.D. Lynch	X	
Sen. Chet Blaylock	X	
Sen. Tom Keating		X
Sen. Gary Hklestad		X

Kelsey Chapman
SECRETARY

Senator Tom Towe
CHAIR

MOTION: By Sen. Blaylock to adopt Items 5, ; 6, ; 7, ; 8 of AFL-CIO Amendments (SB034705.1

ROLL CALL VOTE

SENATE COMMITTEE LABOR ; EMPLOYMENT RELATIONS BILL NO. SB 347

DATE 20 February 1993 TIME 4:54 A.M. (P.M.)

NAME	YES	NO
Sen. Tom Towe		X
Sen. Bill Wilson		X
Sen. Jim Burnett		X
Sen. J.D. Lynch	X	
Sen. Chet Blaylock		X
Sen. Tom Keating	X	
Sen. Gary Hklestad		X

Kelsey Chapman
SECRETARY

Senator Tom Towe
CHAIR

MOTION: By Sen Keating to adopt Items 8 and 9

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on March 10, 1993, at 3:00 p.m.

ROLL CALL

Members Present:
Rep. Chase Hibbard, Chairman (R)
Rep. Jerry Driscoll, Vice Chairman (D)
Rep. Steve Benedict (R)
Rep. Ernest Bergsagel (R)
Rep. Vicki Cocchiarella (D)
Rep. David Ewer (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Evy Hendrickson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 347
Executive Action: SB 347, HB 504, SB 394, HB 587, HB 628

HEARING ON SB 347

Opening Statement by Sponsor:

SENATOR JOHN HARP, Senate District 4, Kalispell, summarized SB 347, an act generally revising workers' compensation law to attain better medical cost containment; revising an injured worker's freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees; amending certain sections and providing an effective date and a retroactive applicability date. **EXHIBIT 1**

SEN. HARP said his amendments address the goal of medical cost

containment and also ensures that everyone who wants to be a participant in this program can be.

SEN. HARP distributed and reviewed his amendments dated March 10, 1993. **EXHIBIT 2**

Proponents' Testimony:

Terry Mitton, representing the **Coalition for Workers' Compensation System Improvement (CWCSI),** said they represent over 50,000 employers and employees and businesses in the state of Montana. They support SB 347.

Jim Puttman, representing the **Coalition for Workers' Compensation System Improvement,** asked the committee to remember that the Coalition, from the very beginning, has been a coalition of workers and employers, the two primary elements in workers' compensation. As amended, this is an outstanding bill. It provides adequate supervision by the Department of Labor; remains cost effective while providing appropriate care; and provides flexibility.

Rick Hill, representing **Governor Racicot's Office,** said the concept of managed care is familiar to most people with medical insurance. This measure would bring proven techniques to the workers' compensation arena. He noted that **SEN. HARP** has spent many hours evaluating the real world of medical costs and medical care as it relates to the workers' compensation situation in Montana. This bill is a Montana solution to the situation. The Governor is an enthusiastic supporter of managed care and asks the committee to give SB 347 a do pass recommendation.

Pat Sweeney, representing the **State Fund,** said they have spent $37 million on medical expenses in FY92 and that medical expenses accounted for over half of the 20% rate increase taken by the State Fund at the beginning of FY93. The cost of workers' compensation insurance is not going to stabilize or decrease if we don't make medical cost containment part of the effort to address the problems facing the system. This bill gives the State Fund and all other insurers the tool to help contain the rise in cost of medical care while providing effective and timely care for insured workers. He added that **Mr. Strizich** of the State Fund has worked on the concepts contained in this bill for over a year and will present specifics on how the bill will work.

Mr. P.J. Strizich, from the **State Fund,** distributed written testimony and charts and gave his presentation. **EXHIBIT 3**

James Tutwiler, representing the **Montana Chamber of Commerce, the Montana Retail Association, Montana Hardware and Implement Dealers,** said they believe SB 347 is a very important piece of legislation aimed at containing medical costs. Employers are being restricted in their ability to provide jobs and pay and

salary increases because of the cost of workers' compensation. **Mr. Tutwiler** said since FY88 the employers in the state have paid about $64 million to support the system, and we are going to have to continue that payroll tax for an indefinite period.

Bill Crivello, Branch Manager for **Crawford Health and Rehabilitation,** representing the **Rehabilitation Association of Montana,** presented written testimony. **EXHIBIT 4**

Harlee Thompson, Manager of Intermountain Truss, and a delegate from the **Montana Building Industry Association** to the **Coalition for Workers' Compensation System Improvement (CWCSI),** submitted written testimony and asked to go on record as recommending a do pass on SB 347. **EXHIBIT 5**

Mike Micone, representing **Montana Motor Carriers Association (MMCA),** said the association would reiterate testimony similar to **Mr. Sweeney** and said they support passage of this bill.

Jacqueline Lenmark, representing the **American Insurance Association (AIA),** said she wanted to address specific concerns AIA has with SB 347 as it is presently drafted and then convey their strong support for the bill. Ms. Lenmark said AIA had one major concern with the bill as it is presently drafted and that goes back to the comments that **SEN. HARP** made about competition. **Ms. Lenmark** commented on the article distributed to the committee members. **EXHIBIT 6** She said that allowing only medical care providers to set up managed care organizations puts control in the hands of the people who have a vested interest in making money in the system rather than allowing competition from all sorts of entities, especially insurers who have a vested interest in keeping costs down. **Ms. Lenmark** then referred to AIA-recommended amendments; reviewed them section by section and asked the committee to add them to the bill. **EXHIBIT 7** She said with these amendments, AIA would support passage of SB 347.

Chuck Hunter, representing the **Department of Labor and Industry (DLI),** said they support SB 347 and outlined the department's role in the bill on managed care. He said this bill would require the department to write rules regarding who may provide managed care and what has to be covered under a managed care plan. He said the statute is quite specific and thinks it is crafted in such a way as to maintain the quality of care that's currently contemplated under the law while providing cost containment and allowing the department to deal with the managed care organization that subsequently does not provide what is intended under the law.

Mr. Hunter said he did not think **Ms. Lenmark's** amendments were needed to get the rules in place.

Bill Egan, representing the **Montana Conference of Electrical Workers (MCEW),** said they rise in support of this bill only if it is amended as proposed by the Senate Labor Committee, and with

the AFL-CIO amendments pertaining to the co-payment which MCEW feels violates the fundamental principle of what workers' comp is and is supposed to be, the secondary medical treatment issue, and also on some parts of the manage care issue.

Riley Johnson, representing **National Federation of Independent Business (NFIB),** said they strongly support SB 347 and the amendments suggested by the sponsor.

Oliver Goe, representing the **Montana Municipal Insurance Authority (MMIA), the Montana School Groups Insurance Authority (MSGIA), and the Montana Association of Counties (MACO),** said the groups he represents are pools that have been put together by the various public entities for the purpose of providing workers' compensation coverage. **Mr. Goe** said they keep very close tabs on all costs, including medical. He said this bill gives them the necessary tools to make a determination about the necessity of different types of care and allows the professionals to make their determinations based upon the information provided.

Jerry Loendorf, representing the **Montana Medication Association,** said they support the bill and specifically want to go on record as supporting Section 12. They would suggest an additional improvement and that being, when an injured worker is referred to a preferred provider, notice is given to the injured worker. **Mr. Loendorf** said notice should be given to the treating physician as well; the reason for this is if the injured worker returns to the treating physician, the treating physician will know he's no longer authorized to provide treatment. If the injured worker does not return but does not notify the treating physician that he has received notice to go to a preferred provider, the treating physician will not be trying to find him for needed treatment.

Mr. Loendorf said if a treating physician has information that is important to the continued treatment of the injured worker, he knows who to pass that information on to. Also, diagnostic procedures and tests can be passed on to the preferred provider to avoid duplicate costs of evaluations and diagnoses.

Tom Ebzery, representing the **Montana Associated Physicians Inc.,** distributed written testimony and addressed the committee. **EXHIBIT 8**

Russ Ritter, representing **Washington Corporations, Missoula,** said they have 13 different companies throughout the state with over 3,000 workers. Managed care, in their judgement, is the key plan in workers' comp reform. He said they strongly support this bill. **Mr. Ritter** said of those 3,000 workers, some 800 are with Montana Rail Link (MRL); since they are all covered under FELA, they would not be covered under workers' comp.

REP. HOWARD TOOLE, House District 60, Missoula, said he supports this bill and said his bill has some of the same goals but takes

a slightly different approach. He said there are some things in his bill that could be incorporated into SB 347 and wants the committee to be aware that there is a difference in the terminology between HB 628 which talks about medical care plans on an individualized basis for the injured worker. **REP. TOOLE** said after reviewing the two bills, they both address different subjects and different portions of the problem and he offered to participate in a merger of the two bills.

Mr. Bob Olsen, representing the **Hospital Association,** said they want to be on record as supporting SB 347.

Bruce Coen, representing the **Montana Optometric Association (MOA),** which represents over 90 optometrists throughout the state of Montana, submitted his written testimony to the committee and stated their support of SB 347. **EXHIBIT 9**

Sam Hubbard, representing the **Deaconess Medical Center of Billings,** said they believe very strongly in the managed care concept contained in this bill and for that reason they urge support of SB 347.

Keith Olsen, Executive Director of the Montana Logging Association, said the state fund work comp rate in Idaho is $28.00; in Montana it is $48.00. Therefore, Montana is not competitive in bidding for federal contracts along our common border. **Mr. Olsen** said Montana needs substantial reform in our system to benefit employers and employees. They believe this bill addresses that, and they urge a do pass.

George Wood, Executive Secretary for the Montana Self Insurers Association, said they support the legislation as amended by the sponsor and recommend a do pass.

<u>Opponents' Testimony</u>:

Roger Tippy, representing the **Montana Pharmaceutical Association,** said they are only opposed to one part of the bill contained in Section 4, page 17 & 18. He distributed his written testimony and discussed it. **EXHIBIT 10**

Don Judge, representing the **Montana State AFL-CIO,** said they believe the legislation is driven by panic founded upon the old workers' compensation debt and it is not the same problem we currently have in the new workers' compensation system. **Mr. Judge** said we have a system that has projected a $42 million deficit based on a 20-year projection and there is currently over $200 million cash in the account of the new fund. He said one of the biggest reasons for rising costs in the system is the cost of health care. He suggested that the committee approach the course of correction with caution.

Mr. Judge said that in the next 20 years, there will be some form

of national health care and perhaps some form of unified, universal state health care program. He said this will significantly reduce the cost of workers' compensation across the country as well as Montana. **Mr. Judge** said the AFL-CIO testified in the Senate and supported this legislation. He said managed care systems are good as long as the injured worker has the initial choice of determining which system they want to use among those managed care providers certified by state government and subsequent disputes would be solved by the Department of Labor.

Mr. Judge said if the employer is paying money to the insurer and the insurer contracts to pay money to the medical care providers, they, in essence, become the company doctor. He said that is not in the best interest of the system or the injured worker. **Mr. Judge** said under this plan the injured worker would go to the company doctor. Regarding co-pays, he said Montana is the only state in the country currently having co-pays.

Barbara Downing, from **Billings**, said she is representing herself and she gave her oral and written testimony to the committee. **EXHIBIT 11** **Ms. Downing** told **SEN. HARP** that she would like to go back to work if she was physically able to. She has 15 years before she can retire and cannot make it on $119.00 a week on workers' comp.

Dan Edwards, Representative, Oil, Chemical & Atomic Workers International Union, AFL-CIO, Billings, gave his written and oral testimony to the committee. **EXHIBIT 12**

Russell B. Hill, representing the **Montana Trial Lawyers Association (MTLA),** submitted his oral and written testimony to the committee. **EXHIBIT 13**

Janice S. VanRiper, Attorney in Helena, said her practice consists mainly of representing workers who are injured, and she has a legitimate concern about these people in the state of Montana. **Ms. VanRiper** said the problem with this bill is it goes too far in decreasing benefits to injured workers and giving unilateral control, in many instances, to the insurance companies. **Ms. VanRiper** submitted her proposed amendments to the committee and reviewed them section by section. **EXHIBIT 14**

Dan Shea, representing himself as an interested citizen, said the co-payment provision of this law is absolutely unfair. He said **SEN. HARP** indicated that it would be $10 a visit or 20%, whichever is less. **Mr. Shea** said if a person goes to physical therapy and it is $50.00 a treatment, for three treatments a week the co-payment would be $30.00 week so, that would be $120.00 a month coming out of their compensation in order to pay for their own physical therapy. He said if it was figured at 20%, it would come out to exactly the very same thing; therefore, that is unfair. **Ms. Shea** said this treats all people the same as to the percentages of what they have to pay without regard to the compensation they are receiving. A high wage earner would be

better able to handle co-payments. **Ms. Shea** said he didn't think there should be a co-payment; but if the committee decides to include them, there should be a sliding scale based on the compensation people are receiving.

Roxanne Verworn, representing herself as a claimant, said the problem she sees with managed care is that we are initially putting the doctors in and keeping them in the insurance companies' pockets. **Ms. Verworn** said when they can recommend who your doctor is going to be, you have a severe problem, especially in Montana where we don't have a lot of competent medical professionals who really care about the injured worker getting back to work. She said she has fought a seven-year battle with workers' comp and still has to have a second back surgery and workers' comp continues to push off what is still an old injury as a new injury. **Ms. Verworn** said the co-payment is absurd and when she was drawing comp benefits she received $122.01 a week. She said she was going to the doctor twice a week and physical therapy five times a week for four months. Her benefits were cut to $45.76 a week without notification and her comp carrier referred her to another physician. **Ms. Verworn** said after receiving the results of the test, the physician told her exactly the opposite of what the test showed. She informed her attorney about the misinformation but, in the meantime, the physician had left town. **Ms. Verworn** said managed care and the co-payment will not handle this situation.

Ms. Dot Stevens, representing herself as a concerned citizen, said there is fraud going on. She said we need more medical training for doctors and we need to get the state involved in ensuring a safe work place. She said when you give an insurer the right to send someone to a physician, they should review the claim to make sure that physician is appropriate for the kind of injury sustained and not send an injured worker to an orthopedic surgeon if they have chemical poisoning.

Jerome Connolly from Billings said he graduated from the Mayo Clinic School of Physical Therapy 21 years ago. **Mr. Connolly** submitted his written and oral testimony on how the current bill functions. **EXHIBIT 15**

Gary Lusin, representing the **Montana Chapter of the American Physical Therapy Association,** submitted his written testimony. **EXHIBIT 16**

Lorin Wright, physical therapist from Red Lodge, thanked **SEN. HARP** for his amendments on the preferred provider organization section. He said Section 6 is too vague and puzzling where it indicates a workers' compensation insurer being contracted with other entities to use the other entities of preferred provider organizations.

Kirk Hanson said he is a self-employed physical therapist representing the **Montana Association of Private Practice Physical**

Therapists. They fully support cost containment and the principles of managed care, but they object to hospitals and large clinics being set up to corner the health care market for injured workers. **Mr. Hanson** said in its present form, SB 347 will not allow self-employed physical therapists to treat injured workers at all, and this will result in the closure of these small businesses. **Mr. Hanson** submitted his written testimony. **EXHIBIT 17**

Richard Smith, self-employed physical therapist in Missoula, said SB 347 promotes the formation of managed care organizations by large corporate institutions. He suggested putting small businesses back in the system, increase the competition and the results will be the costs will go down and quality will go up.

Ann Lawson, owner of a small physical therapy clinic in Kalispell, said competition usually produces a better product. She said currently her costs in Kalispell in providing therapy to an injured worker run about 55% of what it would cost in the hospital in Kalispell and Whitefish. **Ms. Lawson** said her concern is not being able to compete and not even being allowed a chance to treat the workers who self-refer to them because of their reputation. **Ms. Lawson** said she is in opposition to the bill as it's written and is very much in favor of **SEN. HARP'S** amendment on preferred providers.

Questions From Committee Members and Responses:

REP. DRISCOLL asked **Mr. Strizich** to refer to Sections 3 and 5. He said unless the injured worker went to work, he would lose some wages; he asked whether, if the employee was injured at noon, he could go to the doctor. **Mr. Strizich** said he does not put the same interpretation on that. **REP. DRISCOLL** said the injured worker could choose any doctor he wants except he may not choose your doctor unless he's a member of a managed care operation. If the injury results in a total loss of wages for any duration -- for instance, if he lost four hours of wages -- then there would be some loss of wages and if he chose to go to a doctor who is not a member of manage care organization, he couldn't go? **Mr. Strizich** said no, there is an option. It's not 100% required that an employee report to a managed care organization. He said there is an option for the insurer. **Mr. Strizich** said it is optional on managed care. At the point in time when the initial choice physician says the worker is disabled, he has to lose wages, that's when it kicks in, not because someone had to take a half-day off to go to the doctor.

REP. DRISCOLL said that is not what it says. He said after the injured person is treated and has an infection in his arm and the doctor prescribes a brace, is that considered an appliance medically necessary for medical stability? **Mr. Strizich** said yes, if the doctor prescribes it. **REP. DRISCOLL** asked if the doctor prescribes it, then it is not secondary medical services.

Mr. Strizich responded no.

REP. DRISCOLL asked who makes the decision when it's primary and secondary. **Mr. Strizich** said the way the legislation is intended is all the players understand exactly what their role is, and the language goes to the providers. He said if a person has reached stability and their services have nothing to do with impairment or secondary treatment, it might not be allowed by the insurer. **REP. DRISCOLL** asked what medical stability means. **Mr. Strizich** responded that the person has reached maximum medical improvement and there is no expectation that they are going to get any better from medical treatment. **REP. DRISCOLL** asked what is the difference between that and MMI. **Mr. Strizich** said it is essentially the same thing.

REP. DRISCOLL referred to page 6, lines 6 through 8, and said if it means the same thing, then the same words might as well be put back in. **Mr. Strizich** said the old definition was stricken and the new definition is an expansion of that.

REP. DRISCOLL referred to page 11 where it states that the insurer will only pay travel if it is incurred at the request of the insurer, and he asked for clarification. **Mr. Strizich** said if a person had to travel to the nearest medical provider, the insurer would probably pay the travel. He said people will not be stranded because they live in remote areas.

After some discussion, **Mr. Strizich** said the injured person does not attach the deductible to the first visit to the physical therapist or physician. **REP. DRISCOLL** said there needs to be some clarifying language put in the bill because that is not what it states now.

REP. EWER referred to page 5 of the bill and asked **SEN. HARP** what it means that disability does not mean a purely medical condition. **SEN. HARP** said there is an acknowledgment that disability may include something other than a medical condition. **REP. EWER** asked if pain can be a debilitating phenomenon and is that part of the definition of disability. **SEN. HARP** said he could not address the matter in the way it has been described by **REP. EWER.**

REP. EWER asked **SEN. HARP** to respond to **Mr. Judge's** comments on page 11 of the bill. **SEN. HARP** said there are a lot of increased costs in medical service under the current law. At some point, the person paying the bill should have the ability, along with the managed care organization, to show clear evidence that it's cost effective to actually help that injured worker return to work. He said the primary goal of this bill is to help the injured worker through the process to ultimately return to work.

SEN. HARP said he is a union contractor and employs over 100 employees. His policy is when there is an injured worker at any given time, the workers get together and match hours of work. He

said his employees all earn at least $15.00 per hour and if they match four hours, he matches four hours. He described one injury that the company matched over $10,000.

REP. EWER said there is some terminology used in this bill for which the committee doesn't have definitions and he feels that is important. He then reviewed page 15 of the bill and asked if there is much opportunity for a worker to go to an emergency room and have that payable by the State Fund or an insurer, given that this bill is so much of the physician's discretion with the insurer. He also referred to page 18 and said one of the essential points of this bill is, does an injured worker have a choice and can they use their own physician subject to Subsection 3.

SEN. HARP said at the time of the first visit when the injured worker can work outside of managed care and it is the treating physician that he chooses, he doesn't see any problem. He said that 75% of all claims will be excluded from this bill and only about 25% will actually ever see managed care. **SEN. HARP** then referred the question to **Mr. Strizich** with the State Fund.

Mr. Strizich said he understands the concerns but said he doesn't envision any of these kicking in the minute the injured worker walks into the doctor's office. He said after three or four months into a treatment program, if the physician feels there might be permanent impairment, at that point in time managed care comes in. **REP. EWER** then referred to page 21, Section 9, and said there is a lot of terminology in this bill that is not defined. He asked if a health care provider could be a treating physician. **Mr. Strizich** responded yes.

REP. EWER asked if a treating physician jumped through the hoops could he be a managed care provider under this bill. **Mr. Strizich** said yes, it is possible if he can meet all the requirements and certification which entails providing all the necessary medical services.

REP. EWER said his interpretation of this bill is that of trying to ensure that people aren't getting duplicate services, and that is one of the opponents' central problem with this bill. **Mr. Strizich** said if you have two or three things equal, and if the employee has the right to choose between them, you defeat the purpose of preferred providers. **REP. EWER** asked if it is possible to have two preferred providers in the same town. **Mr. Strizich** responded absolutely. He said the purpose of the bill is to allow the insurer to make arrangements to provide all of the necessary medical care and get the best deal they can for it; that is the preferred provider concept.

REP. BENEDICT asked **SEN. HARP** if it was his intent that, if there was not an agreement in place in a small town, the reimbursement rates would be the average wholesale price plus. **SEN. HARP** said definitely, and there was also language added in the Senate

dealing with out-of-state mail order prescription drugs.

CHAIRMAN HIBBARD said a lot of Montana is more than 100 miles from any urban area where a managed care organization would exist, and he asked **SEN. HARP** what his thinking was on that. **SEN. HARP** said managed care will be set up in urban areas. He said in rural Montana, as we know it today, life will continue the way it is has for the injured worker seeing his local physician in most cases. He said the only time that may change is if the treating physician in that community recognizes that there are managed care organizations close to where he might refer that injured worker in rural Montana. In most cases, he doesn't see anything in this bill that would not allow latitude of the insurer. He said they can work outside managed care, and they can work out of an organized group, either PPO or MCO. He said there is flexibility under this bill because rural Montana is recognized. **SEN. HARP** said not every claim and incident in this bill is going to kick in even though **REP. EWER** went through the list.

CHAIRMAN HIBBARD said one of the recurring themes among the opponents was that we may be endangering the exclusive remedy through the 20%, $10.00 charge and more importantly the co-payment provisions and asked for **SEN. HARP's** comments. **SEN. HARP** explained that under work comp there are conditions where employees do not get maximum wages, they get 66 2/3; and there are conditions where it isn't 100% on the benefit side. He said he recognizes the exposure of the small co-payment and it is a matter of saying everybody should have an investment in managed care and medical costs because of the increasing costs.

REP. DRISCOLL referred to page 18, Section 5, lines 18 through 21, and asked for a clarification. If an injured person doesn't ask to change, and he gets to stay with the doctor he wants until you decide he should go to a preferred provider, and you tell him which preferred provider he has to go to, if the claimant doesn't go to them, you don't have to pay the non-preferred provider? **SEN. HARP** said that is correct. **REP. DRISCOLL** asked if the preferred provider is also the managed care person or then do you order me down to Section 7 to a managed care system. **SEN. HARP** said it could be one or the other. If you have a managed care system that is certified and the insurer is contracted with him, you may be directed to them. **REP. DRISCOLL** said he can't see where the person can be ordered to go to a managed care system but they can be ordered to a preferred provider. **SEN. HARP** referred to Section 5 that deals with what happens if a choice is made by the insurer. He said the language reads that the insurer has the choice. He said the insurer cannot direct the person to a managed care organization if there is none, but they can direct to a preferred provider if they have set one up in that particular area.

REP. DRISCOLL said he has a list that is 20 pages long that shows how much money was paid out. In 1992 St. Vincent's Hospital was

paid $2.7 million with a grand total of $20 million paid to medical care providers. He said these are the same people that want to become the managed care people. **REP. DRISCOLL** said they haven't been managing anything now so what is going to force them to manage. There is nothing stated in this bill that forces them to manage. **SEN. HARP** said he disagrees and if we paid $20 million now and the concern is having no control, the law now says we provide reasonable medical services which has been determined by the courts. He said now we are defining what those reasonable services are. **SEN. HARP** said if he finds that St. Vincent's Hospital is overcharging on their services, he will not use them as an insurer.

REP. DRISCOLL asked **SEN. HARP** if he would be willing to amend the bill to say if you order the injured party to one of your doctors, I don't have to pay the $10.00 and they will pay the $10.00 as long as they stay with their physician. He further asked if the person goes to a physician that is not a preferred provider and your preferred provider is going to be cheaper, you are going to save money and then charge me $10.00. **SEN. HARP** said he is not the person to ask if he would support the amendment as this portion of the bill is not his bill. He further said he agreed with **REP. DRISCOLL** but he is not in control of some of those things. **SEN. HARP** then referred to page 15, line 21 of the bill.

REP. DRISCOLL asked if that section means if you request me to go to a managed care system or preferred provider system, I don't pay the deductible? **SEN. HARP** said he did not think so and it deals strictly with examinations.

REP. DRISCOLL asked **SEN. HARP** if he would be willing to amend the bill to say that as long as the injured worker stays with the doctor of his choice, he will pay the deductible, and once he is ordered into managed care or preferred provider, there no longer is a deductible? **SEN. HARP** said that is a good point and he would support that.

REP. COCCHIARELLA referred to page 12, line 9 and asked if medical stability has been defined somewhere or who defines it. **Mr. Strizich** said page 6, line 12 states the definition. He then explained briefly page 12 starting from F.

(Tape 3)

REP. COCCHIARELLA said medical stability to her doesn't mean that person is well and can go back to work. She asked how a person moves on from medical stability. **Mr. Strizich** said if a person is going to a chiropractor and at some point in time the chiropractor says they have reached maximum medical healing, which is the same as medical stability, that may entitle the worker to get his impairment award. He said this bill does not intend to say the injured worker is not entitled to the monthly chiropractic treatment.

REP. EWER asked **Mr. Strizich** if an injured person has to go to the emergency room and there is an attending physician there, is that his first choice. **Mr. Strizich** said the courts have already stated that going to an emergency room is not the injured person's choice of a treating physician and the injured person does not pay the $25.00 for that. He said this is designed to encourage people who may only need a prescription filled or a non-emergency situation to think twice before they rush off to the emergency room.

Closing by Sponsor:

SEN. HARP said he was surprised by the people opposing this bill and the concern about the injured worker that somehow we are affecting the injured worker's ability to receive benefits. He said there is nothing in the bill that lists benefit schedules or where benefits will be reduced with this bill. He said this bill allows quality early return to work in a fair way. He said he views this bill as a pendulum and the pendulum in work comp is completely to one side and out of control. He said this bill is trying to move the pendulum to the middle. **SEN. HARP** said they are trying to look at every avenue in cost containment. He said this bill passed the Senate 48-0.

EXECUTIVE ACTION ON SB 347

Motion: **REP. BENEDICT SB 347 BE CONCURRED IN** and offered amendments. **EXHIBIT 2**

Discussion: **REP. BENEDICT** offered the amendments that **SEN. HARP** provided to the committee. He said that **SEN. HARP** has stayed within his main goal of cost containment to deal with the out of control situation of medical costs in workers' comp. He said he is very appreciative of the work that has been done on this bill.

Vote: Motion to adopt amendments carried unanimously. **EXHIBIT 18**

Motion: **REP. DRISCOLL** moved the amendments dated March 10, 1993. **EXHIBIT 19**

Discussion: **REP. DRISCOLL** discussed the amendments dated March 10, 1993 by Susan Fox. **REP. EWER** said the committee knows what the intention is and they rely on the legislative staff to clean it up. **REP. DRISCOLL** said he would support the amendments and with the concurrence of **SEN. HARP** they are good amendments.

Motion/Vote: **REP. BENEDICT** called the question.

Vote: Motion to adopt amendments carried with **REP. COCCHIARELLA** voting no. **EXHIBIT 20**

Motion: **REP. DRISCOLL** moved the amendments dated March 19, 1993.

Discussion: **REP. DRISCOLL** reviewed the amendments dated March 19, 1993 prepared by **Susan Fox** section by section.

Mona Jamison, representing the **Montana Chapter of the Physical Therapy Association (MCPTA)**, was asked to expand on Section 6 of the amendments. She asked the committee to notice that, with the authorization of a treating physician, before this can actually occur where the injured worker is immediately seeing the physical therapist, the treating physician is authorizing that. She said this means that immediate physical therapy is sound and will help get the injured worker back to work quickly. She said there is no need to put this worker into managed care when the treating physical therapist determines this will best serve the injured worker. She said this section will keep costs down.

REP. DRISCOLL continued reviewing the amendments.

SEN. HARP said with the amendments he offered, if the treating physician has an interest in the facility, unless it's in a small community, they will no longer be allowed to treat the injured person unless the insurer authorizes this. He said there is flexibility and in some cases it would be allowable.

REP. DRISCOLL said he would withdraw that amendment. He then asked if the insurer says it's okay for this person to take X-ray's, blood tests, etc., then it's paid for; if they started using it, then they could say no, we're not paying for anything inside your office except your office call?

Mona Jamison said amendments number 11, 12 and 14 on page 2 now being discussed that were prepared by **Ms. Fox** should be stricken. She said they have been taken care of through other amendments.

CHAIRMAN HIBBARD said numbers 3, 5, 8, 10, 11, 12, 13, 14, 15 & 16 have been stricken. He said 1 & 2 go together and 4, 6, 7 & 9 remain.

REP. BENEDICT said the committee has gone as far as possible to try to make this a perfect bill for everyone.

Motion/Vote: **REP. DRISCOLL** called for the question. Motion failed 3 to 3 with **CHAIRMAN HIBBARD AND REPS. BENEDICT AND BERGSAGEL** voting no. **EXHIBIT 21**

Tape 4. Side 1

Motion/Vote: **REP. BENEDICT** called the question on the motion **SB 347 BE CONCURRED IN AS AMENDED.** Voice vote. Motion carried unanimously.

HOUSE SELECT COMMITTEE REPORT

March 11, 1993
Page 1 of 1

Speaker: We, the select committee on Workers' Compensation
mmend that Senate Bill 347 (third reading copy -- blue) do
oncurred in as amended, and that the House refer the bill
amendments to the House Committee on Labor and Employment
tions for its consideration as part of the Workers'
ensation package.

Signed: Chase Hibbard
Chase Hibbard, Chair

that such amendments read:

age 15, line 6.
owing: "for"
rt: "20%, but not to exceed"
owing: "$10"
rt: ","

age 15, line 8.
owing: "disease"
rt: ", unless the visit is to a medical service provider in a
managed care organization as requested by the insurer or is
a visit to a preferred provider as requested by the insurer"

age 20, lines 3 and 4.
owing: "~~or~~" on line 3
ke: the remainder of line 3 through "pharmacies," on line 4

age 20, line 5.
owing: "goods"
ke: ","
owing: "and"
ke: "other"

age 27, line 8.
owing: "prohibition."
ke: "A"
rt: "Unless authorized by the insurer, a"

age 27, lines 9 and 10.
owing: "facility" on line 9
ke: the remainder of line 9 through "practice" on line 10

ittee Vote:
5, No 1.

551221SC.Hpf

9. Page 23, line 24.
Following: "noncompliance."
Insert: "(1)"

10. Page 24, line 4.
Strike: "(1)"
Insert: "(a)"

11. Page 24, line 5.
Strike: "(2)"
Insert: "(b)"

12. Page 24, line 7.
Strike: "(3)"
Insert: "(c)"

13. Page 24, line 9.
Following: line 8
Insert: "(2) A worker may appeal the termination of compensation benefits through procedures established by the department."

14. Page 25, line 18.
Following: "prevailing"
Strike: "minimum"

15. Page 25, line 19.
Following: "than"
Strike: "8"
Insert: "the required number of"

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL DATE 3-10-93

NAME	PRESENT	ABSENT	EXCUSED
CHASE HIBBARD, CHAIRMAN	✓		
JERRY DRISCOLL, VICE CHAIRMAN	✓		
STEVE BENEDICT	✓		
ERNEST BERGSAGEL	✓		
VICKI COCCHIARELLA	✓		
DAVID EWER	✓		

HR:1993
wp.rollcall.man

EXHIBIT 1
DATE 3-10-93
HB SB 347

TESTIMONY ON SENATE BILL 347
By Senator John Harp

House Select Committee on Workers' Compensation
March 10, 1993

This bill represents the first comprehensive revision of the medical delivery system under the Workers' Compensation Act. The Workers' Compensation Act provides an injured worker with payment of "reasonable" medical expenses. This bill affords the Legislature the opportunity to determine what are "reasonable" medical services, instead of leaving it up to the courts to make that decision. Cost containment is the principle upon which the bill is based but its purpose also is to provide timely and effective medical services to injured workers.

MANAGED CARE

A key component of this bill is managed care. Managed care is defined in section 8 as:

> A program organized to serve the medical needs of injured workers in an efficient and cost effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to section 6 through appropriate health care professionals.

The managed care organization is to provide <u>all</u> primary medical services to an injured worker who loses wages for any duration, has permanent impairment, needs referral to a specialist for treatment or requires special, and costly diagnostic procedures. The insurer will have the right to designate the managed care organization and will not be liable for medical services obtained outside the managed care organization, unless the insurer authorizes the care, or emergency care is necessary. The designated treating physician in the managed care organization then becomes the worker's treating physician.

The Department of Labor will establish criteria pursuant to section 9 to certify managed care organizations. Once certified, insurers may contract with the

organizations to provide medical services for injured workers. Insurers will be required to give written notice to workers regarding managed care organizations. Reimbursement for travel has been restricted by this bill unless the travel is incurred at the request of the insurer. As managed care will be at the request of the insurer when the worker is subject to managed care, travel related to treatment from the managed care organization will be reimbursable. Managed care organizations, based on the size and population distribution in Montana, will likely only be established in the state's largest cities.

FREEDOM OF CHOICE

Freedom of choice of the treating physician has been deleted for workers' compensation insurance from Title 33. Treating physician is defined in the bill. However, if a worker is subject to managed care, the managed care organization then designates the physician who becomes the worker's treating physician and becomes primarily responsible for the worker's treatment. If a worker is not subject to managed care, or if the insurer authorizes the care, a worker may chose and continue to receive care from the worker's choice of initial treating physician. However, a worker may receive immediate emergency care from a physician and then chose an initial treating physician, unless the worker then becomes subject to managed care.

PREFERRED PROVIDERS

Use of preferred provider organizations by insurers is encouraged under this bill to promote cost containment of medical care. Insurers may establish such arrangements with medical providers. A preferred provider organization may be established with the managed care organization or a preferred provider organization may be established independently of a managed care organization with any providers. A worker receiving care from a managed care organization might be directed to a preferred provider organization for medical goods, however a managed care organization could be a managed care preferred provider.

PRIMARY AND SECONDARY MEDICAL SERVICES

A distinction is made between "primary" and "secondary" medical services and puts restrictions tied to cost effectiveness, on those services which are not necessary to achieve medical stability. Secondary medical services will be paid by the insurer if it is demonstrated they are cost effective in returning the worker to employment. Both services are defined in the bill. The secondary services definition was amended to reflect programs addressing disability and for this section a definition of disability was added to the bill.

PALLIATIVE AND MAINTENANCE CARE MEDICAL SERVICES

Restrictions are also placed on "palliative" and "maintenance care", unless, it clearly enhances employment, or is for a permanently totally disabled worker to monitor medication or monitor the status of a prosthetic device.

ROLE OF DEPARTMENT OF LABOR

The Department of Labor's functions are important to this bill as it fulfills a neutral regulatory role in regards to medical services that are provided to injured workers by the insurers. Their functions in this bill are to certify managed care organizations after establishing the criteria and rules, develop utilization and treatment standards in conjunction with standing medical advisory committees, establish physician panels and review requests for approval of palliative or maintenance care, establish rates for hospital services, adopt rules excluding from compensability medical treatment that is unscientific, unproved, outmoded, or experimental and provides hearings for disputes between an insurer and a medical service provider.

It is intended that the medical advisory committees would be established either with all representatives from the same provider group or in various appropriate combinations.

EXHIBIT 1
DATE 3-10-93
SB 347

GENERIC DRUGS

This legislation calls for reestablishing reimbursement rates for prescription drugs similar to the methods used by Medicaid, and also requires generic drugs to be used unless unavailable.

HOSPITAL RATES

Hospital reimbursement rates established by the Department of Labor may be based on a per diem or diagnostic-related groups. These methods are those used by other types of insurers and a delayed effective date to January 1, 1995 is provided for in order for the Department of Labor to properly establish this process. The rates effective 1/1/95 may not be less than Medicaid reimbursement rates, and it is contemplated that the Department of Labor will use a system similar to Medicaid's. Currently, the bill's intent is to allow the Department of Labor to follow their current rate setting process, subject to 39-71-704(4), without regard to the Medicaid reimbursement rates. Time for the Department of Labor to change the process is necessary, and it also gives insurers time to reprogram computers.

COMPLIANCE WITH MEDICAL TREATMENT

Compliance with medical treatment is required under this bill, and an insurer may terminate benefits upon 14 days notice for failure to cooperate with the managed care organization or the treating physician, submit to medical treatment except for invasive procedures or provide access to health care information. This section is intended to be an option available to insurers, and in addition to or instead of any remedies provided for in 39-71-605 and 607.

DOMICILIARY CARE

Domiciliary care is also addressed in this bill. The criteria for domiciliary care is placed in the law and requires the care to be provided by a nurse if professional nursing care is required. Care that is required on a 24-hour basis but does not require the services of a professional nurse may be provided by a family

member but is limited to the statewide daily average reimbursement rate for nursing homes by Medicaid. The average rate right now is $67.15 per day. Currently a family member may be reimbursed up to $180.00 per day. Domiciliary care required for less than 24 hours a day by a family member is limited to the primary wage and a maximum of 8 hours per day. The prevailing wage, based on the level of care provided could potentially range from minimum wage to approximately $7.50 per hour.

CO-PAYMENT

This bill has unique provision on a co-payment by a worker. After the initial treatment, a worker is liable for $10.00 for every visit, and visit is defined in the bill. The worker will also be liable for $25.00 of every visit to a hospital emergency department after the initial treatment. My understanding is that workers' compensation insurance is the only form of medical insurance without a deductible or co-payment provision. Medical payment prior to the early 70s was limited as to time and dollar amount. This provision is not inconsistent with other workers' compensation benefits in that a deduction exists in the 6-day waiting period to receive wage loss compensation benefits, the wage rate itself is 66 and 2/3 of the worker's average weekly wage and permanent partial and permanent total benefits have statutory limits. The Workers' Compensation Act currently in its declaration of public policy states wage loss benefits are not intended to make a worker whole but are intended to assist a worker at a reasonable cost to the employer.

SELF REFERRAL

This bill also contains a provision on self referral by physicians. If a provider is referring a claimant to a health care facility outside the physician's office and the physician does not directly provide the services there and the physician has an investment interest in the facility, the insurer is not liable for charges incurred. An exception is if there is a demonstrated need in the community for the facility and

EXHIBIT 1
DATE 3-10-93

alternative financing is not available. This provision is consistent with the recent resolution by the American Medical Association.

FREEDOM OF CHOICE - RETROACTIVELY

This bill's amendment of the "freedom of choice" provision in §33-22-111, MCA, is also applicable because of the recent Workers' Compensation court decision in *Wieland v. State Fund*, WCC No. 9208-6554. In the *Wieland* case, the Court directly contradicted a 1978 Supreme Court decision *Garland v. Anaconda Co.*, 177 Mont. 260 (1978) that had upheld the Department of Labor rule concerning choice of physicians, in spite of an argument in *Garland* that the freedom of choice statute rendered the rule invalid.

Garland held that a claimant must have prior authorization from an insurer to change physicians. A Department of Labor rule, 24.29.1403, also requires authorization from the insurer to change physicians.

Section 33-22-111, MCA, allows for freedom of choice under the Workers' Compensation Act (amended in SB 347, p. 2, and then separately defines treating physician on p. 9).

The impact of this case is that a claimant does not need approval from the insurer to change doctors, therefore ability to seek treatment from different physicians would be unlimited. The curative legislative, section 16, is necessary to resolve the conflict in the Workers' Compensation Court's interpretation.

The Workers' Compensation Court currently has the case on a request for a rehearing. It may reconsider its decision, or the Supreme Court may very well reverse.

The National Council on Compensation Insurance, NCCI, is an organization of which the State Fund and the private insurers must belong. One of their actuaries priced this bill for the State Fund and determined that bill would save approximately $7 to $8 million annually for the Sate Fund.

Oregon used managed care and other concepts which this Legislature is also addressing in this and other bills, in the reform of their workers' compensation system with positive results. Montana should do no less. I urge this Committee to pass this bill.

EXHIBIT 1
DATE 3-10-93
SB 347

EXHIBIT 2
DATE 3-10-93
~~HB~~ SB 347

Amendments to SB 347
Third Reading

House Select Committee on Workers' Compensation
Requested by Senator John Harp
March 10, 1993

1. Page 15, line 6.
Following: "for"
Insert: "20%, but not to exceed"

2. Page 15, line 6.
Following: "$10"
Insert: ","

3. Page 20, lines 3 and 4.
Following: "~~or~~"
Strike: the remainder of line 3 through "pharmacies," on line 4

4. Page 20, line 5.
Following: "and"
Strike: "other"

5. Page 27, line 8
Following: "prohibition."
Strike: "A"
Insert: "Unless authorized by the insurer, a"

6. Page 27, line 9 and 10.
Following: "facility"
Strike: "the remainder of line 9 through "practice" on line 10

EXHIBIT 3
DATE 3-10-93
HB SB 347

Testimony in support of SB347 P. J. Strizich - State Fund

I would like to give you a quick glance at the reasons we feel the reforms presented in this bill are necessary. I would like to give an illustration which represents a glaring example of the issue of medical care to injured workers under the current statutes.

The charts I have handed to you represent figures published in the annual report to the governor by the Department of Labor and Industry and the State Fund. The first chart reflects the number of injuries reported, industry wide, for fiscal years 81 through 92. The second chart reflects the total medical benefits paid for the same periods. The third chart represents the average cost of medical services per accident. The average cost per accident has increased 402% over the 11 year period. This amounts to over 36% per year.

During the same period, the state's average weekly wage, which is a reflection on the overall economic status of Montana's workers, and is used to determine the maximum compensation rates paid to injured workers, rose from $219.00 in FY81 to $336.00 in FY 92, for a total increase of 65%. The yearly average increase is less than 6%. The simple truth is that medical costs have increased six time faster than compensation rates. Up until now, insurers have been obligated to deliver "reasonable" medical services to injured workers. If the increases just demonstrated are reasonable, then this bill in unnecessary.

According the State Fund's actuary, more than half of the most recent rate increase by the State Fund is attributable to the uncontrolled increases in medical benefit payments.

One of the areas representing the greatest waste in the system is duplication of services. It is not unusual to observe case files where the injured worker has been given two or three of the same diagnostic test, such as MRI's, by the same or two or three providers involved in treatment. Each one costs a thousand bucks. It is not unusual to see the same conservative treatment modalities, such as physical therapy, prescribed two or three times. If the first one was ineffective, does it make any sense to continue to try it? Each time the patient is sent can cost two or three thousand bucks. These abuses will be eliminated under this proposal.

Another area of waste is the delays in services. If a treating physician refers the patient to a specialist, an orthopedic surgeon perhaps, everything is on hold just waiting for the appointment, which may be six or eight weeks down the road. If the patient is receiving the maximum compensation rate payable today of $349.00 per week, six weeks amounts to almost $2,100.00. The managed care proposal in this bill is designed to prevent delays in treatment.

You no doubt will hear opposition to this bill, from troughers, who have many reasons to object to all or parts of this legislation. You will probably have requests to amend the language so that their special interests are addressed. Chiropractors may have the feeling that they have been singled out for exclusion. They have not. They are treated no differently than any other physician, including orthopedists, neurosurgeons or any other provider not part of a managed care organization. There is nothing in this bill to prevent physicians, chiropractors, optometrists, or any other provider from becoming a part of a managed care organization.

Physical Therapists, particularly those with independent practices, have expressed concerns that managed care will prevent them from treating workers' compensation patients. Again, there is nothing in this bill to prevent them from affiliating with managed care organizations. Physical Therapy will still be necessary. Currently, a prescription from the attending physician is necessary for them to treat injured workers. The same will be true under this bill. There is no reason to use this legislation as a vehicle for the advancement of special interests.

As the largest single payer of medical benefits under the workers' compensation system, the State Fund is aware of these concerns. In evaluating the respective opposition to this bill, please bear in mind that the purpose of the legislation is to provide a systematic, defined method to deliver medical services to all injured workers in Montana, whether they have been severely burned or have a foreign body in their eye, whether they suffer from a hernia or have a simple back strain, whether they require surgery or not. The managed care system created by this bill will provide the necessary, quality treatment to all injured workers in the most cost effective manner.

For the first time in our history, you have been asked to address, by way of a major reform, the system which delivers medical care to injured workers. The State Fund encourages a do pass vote from this committee.

EXHIBIT 3
DATE 3/10/93
SB 347

Amendments to SB 347
Third Reading

House Select Committee on Workers' Compensation
Requested by Senator John Harp
March 10, 1993

1. Page 15, line 6.
Following: "for"
Insert: "20%, but not to exceed"

2. Page 15, line 6.
Following: "$10"
Insert: ","

3. Page 20, lines 3 and 4.
Following: "~~or~~"
Strike: the remainder of line 3 through "pharmacies," on line 4

4. Page 20, line 5.
Following: "and"
Strike: "other"

5. Page 27, line 8
Following: "prohibition."
Strike: "A"
Insert: "Unless authorized by the insurer, a"

6. Page 27, line 9 and 10.
Following: "facility"
Strike: "the remainder of line 9 through "practice" on line 10

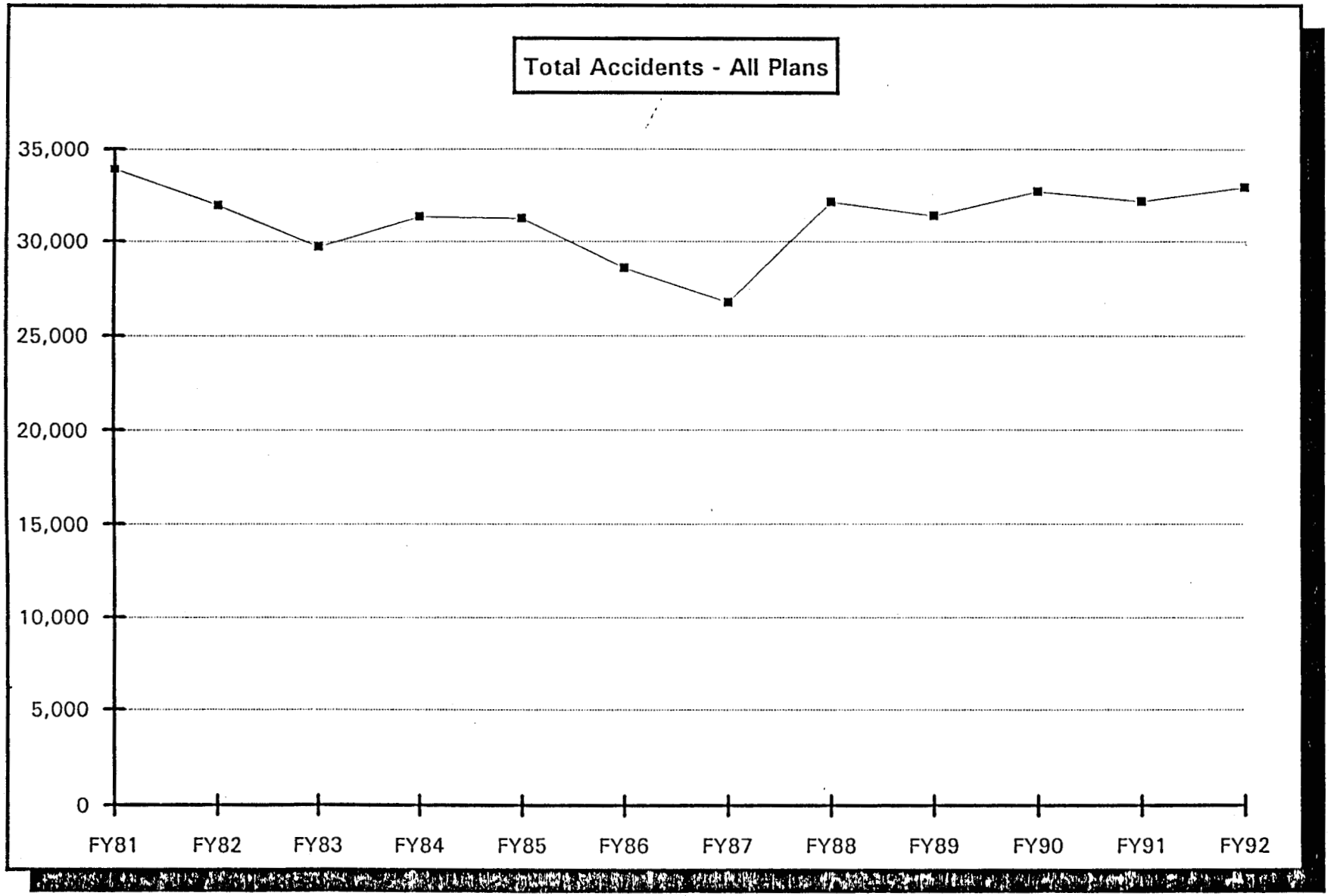


EXHIBIT 3
DATE 3/10/93
SB 347

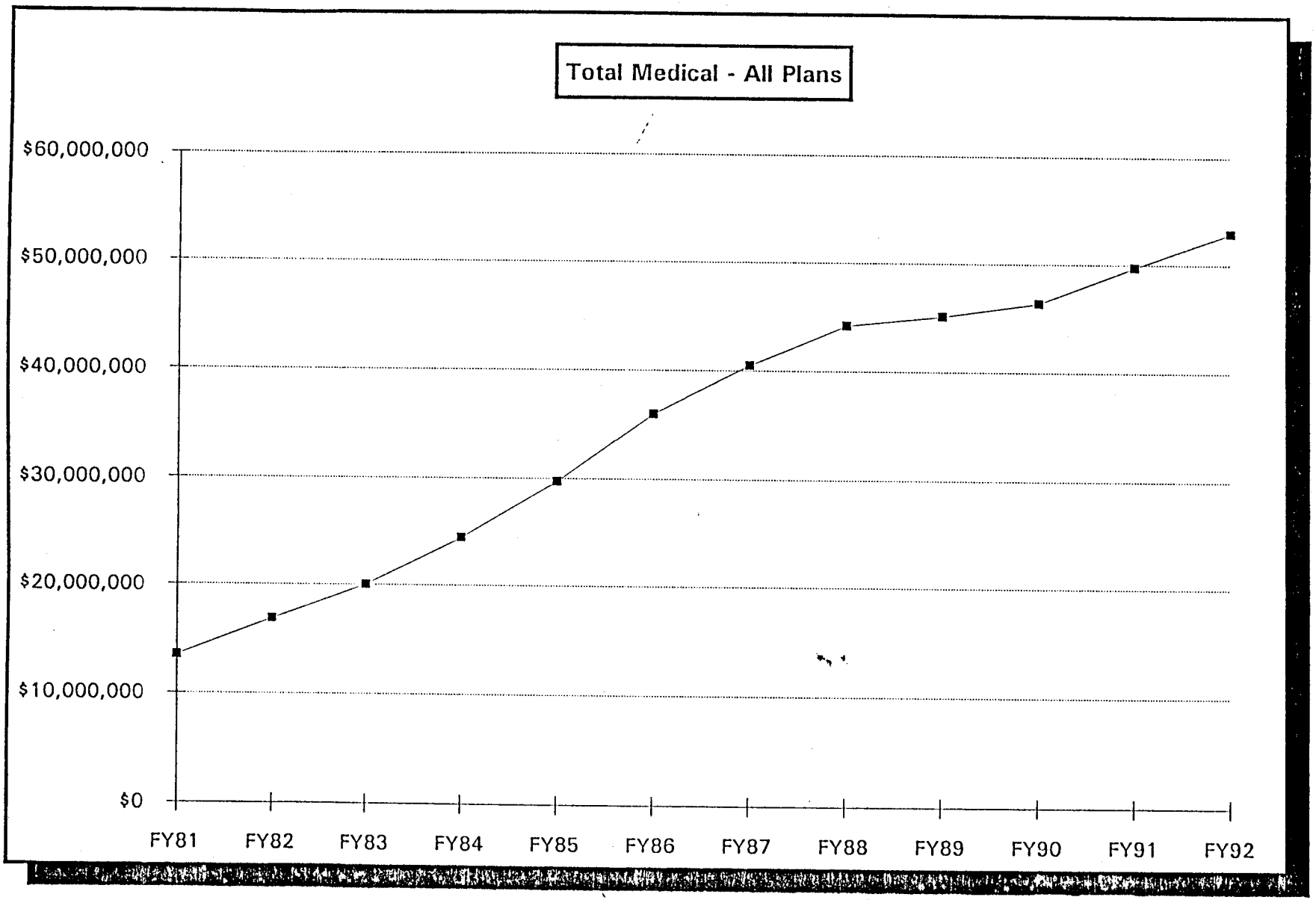


EXHIBIT 3
DATE 3/10/93
SB 347

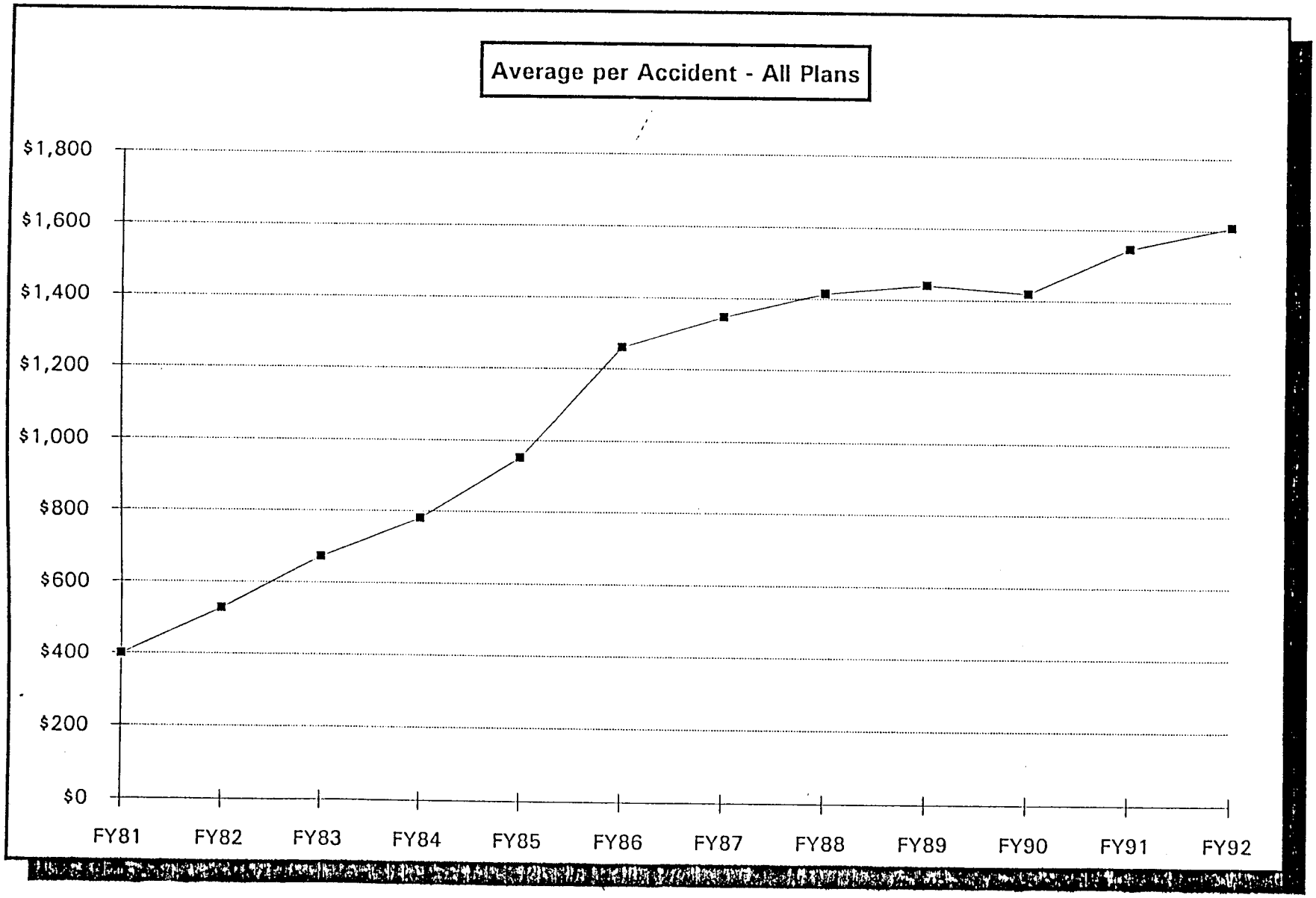


EXHIBIT 3
DATE 3/10/93
SB 347

EXHIBIT 4
DATE 3-10-93
HB SB 347

RAM
Rehabilitation Association of Montana

March 10, 1993

Mr. Chairman, Members of the Committee:

For the record, my name is Bill Crivello. I am a Branch Manager for Crawford Health & Rehabilitation, and I am also representing the Rehabilitation Association of Montana. In the interest of time, I am providing written testimony which I would request that you please take the time to review. In particular, I would like to draw your attention to my written remarks as a manager for Crawford Health & Rehabilitation, and my specific concerns and recommendations as they relate to your intentions regarding what type of managed care programs will be allowed to participate in the workers' compensation arena.

The Rehabilitation Association of Montana supports the concept of cost containment through the provision of managed care. We feel that Senate Bill 347 is a move in the right direction. However, we also wish to express our opinion that existing managed care and medical case management programs in the private sector which utilize nurse medical coordinators and case managers should be an optional model for utilization in the workers' compensation field. The language of Senate Bill 347 substantially focuses on a model which places managed care responsibility in the hands of treating physicians. We recognize that the Bill was rewritten with language intended to broaden the scope of potential alternative managed care efforts, and we draw attention to the specific language on Page 24, lines 6 and 7, where it reads ". . . a group of medical service providers or an entity with a managed care organization. . ." can provide managed care under specific provisions of the Bill.

While we have stopped short of opposing this Bill, we encourage the Committee to either consider amendments which would more clearly allow insurers the option to select an appropriate managed care program, or to establish a clear legislative record with regard to this intent.

We also note that when Senate Bill 347 was passed out of the Senate, additional language was written into it on Page 5, providing a definition of "disability". This definition appears to incorporate vocational terminology in defining disability, and we would like to request clarification as to its purpose for being included. Thank you.

Sincerely,

Bill Crivello

Bill Crivello, Legislative Chair

EXHIBIT 4
DATE 3/10/93
SB 347

CRAWFORD & COMPANY
HEALTH AND REHABILITATION

WILLIAM J. CRIVELLO
BRANCH MANAGER

March 3, 1993

Mr. Chairman, Members of the Committee:

For the record, my name is Bill Crivello. I am a Branch Manager for Crawford Health & Rehabilitation. Our firm is a nationally-based health care management firm with seven offices in the state of Montana.

I would like to preface my remarks by first stating that I've known Senator Harp for several years, having worked with him several years ago when I resided in the Flathead Valley. I have a great respect for his integrity, and more specifically, I fully support his intentions and hopes with regard to the objectives of Senate Bill 347. Further, I have worked closely with Mr. Pete Strizich at the State Fund for the past several years, and I know that he, too, is faithfully and professionally committed with regard to the intentions and objectives underlying his drafting for language contained in this Bill. Senator Harp allowed me the opportunity on a number of occasions to meet with him and Mr. Strizich, as well as others, in an effort to refine some of the language and the fine points of this Bill. My initial involvement in discussions was admittedly non-supportive, as I had professional difference of opinion with regard to the physician/gatekeeper model outlined in the managed care component of this Bill.

To put it simply, and in an effort to keep my remarks brief, the type of managed care postulated in this Bill is not the type of managed care which our company promotes and provides. To the credit of Senator Harp, I, and a number of other individuals who are not directly involved in providing managed care, was successful in having alternative language placed into this Bill which would at least theoretically allow existing managed care organizations such as ours to operate within the scope of managed care in workers' compensation. I refer you, specifically, to Page 23, line 6 and 7, where it reads ". . . a group of medical service providers or an entity with a managed care organization . . ." can provide managed care under certain provisions.

In retrospect, and having analyzed the Bill in more detail, I am not convinced that the type of managed care which we presently provide will be certifiable under the Department of Labor requirements outlined in Section 9. Like most managed care systems throughout the country, Crawford Health Care Management provides a Nurse-Case Manager model, and is not physician-based, as is contemplated throughout the various managed care sections of this Bill. While I fully appreciate and wholeheartedly support the goal of containing medical costs through managed care, I still do not believe that the physician/gatekeeper model

is the one and only solution to address the issues inherent to the system. My goal here is merely to insure that insurers have the freedom to select the model which they feel will work for them.

Yesterday, by way of example, I had occasion to review a case which we were closing with regard to medical case management. This case was referred to us by a Workers' Compensation Claims Adjuster in the Fall of 1991. The Adjuster was plagued with repeated instances of the injured worker going to the Emergency Room for treatment, and being unnecessarily hospitalized for continued pain and symptomology. Despite indications from the attending physician that the costly Emergency Room visits and hospitalizations were not necessary, the physician did nothing to circumvent the problem, or identify more appropriate solutions. The situation went uncontrolled, with costs continuing to soar with each new hospitalization. Our Nurse/Case Manager was asked to intervene, and to become involved directly with the physician, to formulate a more viable treatment plan. Subsequently, the claimant was encouraged, counseled, and finally directed not to utilize the Emergency Room and hospitalizations for treatment. By obtaining the commitment to this treatment plan from her attending physician, the insurer was able to eliminate the inappropriate hospitalizations, and they have now gone 14 months with no hospitalizations. Additionally, we have assisted in discontinuing repeated physical therapy and work hardening, which had been ongoing, despite lack of progress for the claimant. In the alternative, the claimant has been enrolled in a health club program, and is now involved in home exercise and health club conditioning, in lieu of the more expensive physical therapy, which had not resulted in any significant benefit. The medical cost savings realized as a result of our intervention was in excess of $13,000, for the past year alone. If the claimant continues to follow the revised treatment plan, and unnecessary hospitalizations continue to be avoided, additional savings of approximately $5,000 per year will be realized. This type of savings is not unusual with regard to the type of managed care which we presently provide for workers' compensation cases. And, it is certainly found to be desirous by many insurers.

I fully recognize that the State Fund is committed to implementation of the physician/gatekeeper managed care model. However, numerous clients that we presently serve have indicated that they would like to continue utilizing our type of managed care in workers' compensation, and they do not plan to utilize the physician-based model. It is my hope that you will allow us to continue providing managed care, and to do it within the scope of the workers' compensation managed care legislation.

I am offering several amendments here which I believe will allow the Department of Labor to exercise reasonable and fair judgement with regard to managed care application which we or others might present to them. It is my belief that these amendments will allow the Department to establish the required rules for

application and certification, but allow for the potential certification of managed care programs which are not necessarily physician based.

If you see fit to accept these amendments, or--IN THE ALTERNATIVE--if you can clearly document in the Legislative Record that it is not your intention to exclude managed care efforts which are non-physician-based, I believe you will broaden the perspective of managed care within workers' compensation and will allow insurers to exercise an element of selection with regard to how they feel they can best provide managed care and realize the resultant cost savings. Thank you for your consideration.

Respectfully submitted,

William J Crivello

William J Crivello, M.S., C.R.C.
Branch Manager
CRAWFORD HEALTH & REHABILITATION SERVICES

WJC/kv

ENCLOSURE: PROPOSED AMENDMENTS

EXHIBIT 4
DATE 3/10/93
SB 347

EXHIBIT 4
DATE 3/10/93
SB 347

3/10/93

PROPOSED AMENDMENTS TO SENATE BILL 347

1. PAGE 18, LINE 25, NEW SECTION - SECTION 5, AFTER WORD "OF",

   INSERT: "OR COORDINATING SERVICES WITH"

   LINE SHOULD READ: AS A TREATING PHYSICIAN, BUT WHO IS NOT A MEMBER OF OR COORDINATING SERVICES WITH A MANAGED

2. PAGE 19, LINE 14, NEW SECTION - SECTION 5, AFTER WORD "FROM"

   INSERT: "OR THROUGH"

   LINE SHOULD READ: INSURER, RECEIVE MEDICAL SERVICES FROM OR THROUGH THE MANAGED CARE

3. PAGE 19, LINE 16, NEW SECTION - SECTION 5, AFTER WORD "PHYSICIAN"

   INSERT: "WORKING WITH OR"

   LINE SHOULD READ: THE DESIGNATED TREATING PHYSICIAN WORKING WITH OR IN THE

4. PAGE 22, LINE 2, NEW SECTION - SECTION 9, AFTER WORD "PROVIDER"

   INSERT: "OR HEALTH CARE MANAGEMENT ORGANIZATION"

   LINE SHOULD READ: THEN A HEALTH CARE PROVIDER OR HEALTH CARE MANAGEMENT ORGANIZATION

5. PAGE 22, LINE 14, NEW SECTION - SECTION 9, AFTER WORD "INDIVIDUAL"

   INSERT: "OR IDENTIFY THE TYPES OF INDIVIDUALS"

   LINE SHOULD READ: A LIST OF NAMES OF EACH INDIVIDUAL OR IDENTIFY THE TYPES OF INDIVIDUALS WHO WILL PROVIDE

6. PAGE 22, LINE 19, NEW SECTION - SECTION 9, AFTER WORD "INDIVIDUALS"

   INSERT: "OR IDENTIFY THE TYPES OF INDIVIDUALS"

   LINE SHOULD READ: NAMES OF THE INDIVIDUALS OR IDENTIFY THE TYPES OF INDIVIDUALS WHO WILL BE DESIGNATED AS

RATIONALE

Crawford Health & Rehabilitation Services, a national Health Care Management organization, has been providing vocational and medical case management services in Montana for several years. Medical case management provided by private sector firms such as ours has become more and more commonplace in the workers' compensation arena, and is utilized by private insurers, self-insurers, and the State Compensation Mutual

Insurance Fund for cost-containment purposes. While the State Fund has expressed definite commitment toward utilizing the physician/gatekeeper model for medical case management and managed care, many of our clients--workers' compensation insurers--have expressed concern and apprehension with regard to utilization of the physician-based managed care model. Private managed care organizations have had an excellent track record in providing medical case management services for workers' compensation cases. Our nurse case managers have the experience and training necessary to continue to provide managed care, without requiring insurers to consider only a physician-based model. Recognizing that different workers' compensation insurers may wish to select different types of managed care efforts, these amendments will allow them continued use of this model, or other alternatives, within the parameters and intent of the proposed legislation.

We believe that the amendments offered do not detract from the intent of this legislation, but will allow the Department of Labor to certify current managed care programs, such as ours, to continue to provide this type of service in the area of workers' compensation.

EXHIBIT 4
DATE 3-10-93
SB 347

ilders Assoc. of Billings
3

ntana Home Builders Assoc.
1

lls Homebuilders Assoc.
ME

Flathead Home Builders Assoc
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

EXHIBIT 5
DATE 3-10-93
SB 347
HB

SB 347

Workers Comp Medical Cost Containment

Recommend:

Do Pass

Mr. Chairman, members of the committee:

I am Harlee Thompson, manager of Intermountain Truss, and a delegate from the Montana Building Industry Association to the Coalition for Work Comp System Improvement (CWCSI).

No one usually argues that one of the major problems in the Worker's Comp system is the lack of specific injury definition. This has left the matter to the jurisdiction of medical practitioners who tend to over treat to avoid liability; lawyers who are eager to ask the court for an interpretation of the injury; and confused claims examiners who deal with a variety of diverse court interpretations.

The Coalition for Work Comp System Improvement believes that the creation of stricter injury definitions will not limit benefits--only provide clear instructions for all, whether they be claimants, medical providers, employer or insurers.

The definitions of injuries contained in SB 347 gained bipartisan support during the recent election and are an important step in eliminating vagueness in current law.

SB 347 also will help eliminate another costly area of the current system. With the creation of preferred provider organizations and the ability of insurers to contract with managed care organizations the costly practice of duplicating of services should be eliminated. This should also speed up the process in which the injured worker receives treatment and will hasten their return to work.

We urge a do pass committee recommendation.

IW
INSURANCE WEEK

EXHIBIT 6
DATE 3-10-93
HB SB 347

FEBRUARY 22, 1993

WORKERS' COMPENSATION

9 Survey — Many Condone Fraudulent Claims Behavior

10 A Private Insurer's Perspective Of Oregon's 'Success Story'

12 Washington USL&H: Permanent Solution Not Visible on Horizon

14 Calif.'s Crisis: Reform Is Not Imminent, But It's Inevitable

16 Does Benevolent ERISA Plan Pose Ultimate Threat in Calif.?

We stand mountains and treetops above the rest. We love the West. And it shows.

Our local North Pacific offices have been serving you since 1926, providing a solid line of personal and commercial insurance. Today, we're one of the area's largest insurance companies with a Best's A+ rating . . . and a commitment to the Northwest's independent insurance agents. Besides fast claims service and competitive rates, we continue with our tradition of giving our customers personal service and attention.

So when it comes to strength, commitment, an insurance line you can sell and a feel for the West, count on us. Because we're mountains and treetops above the rest.

North Pacific Insurance Company

We're that good. Oregon Washington Idaho Utah

1675 S.W. Marlow Ave., Portland, OR 97225 503/643-7661 Member, General Accident Insurance

EXHIBIT 6
DATE 3/10/93
SB 34

WORKERS' COMPENSATION

A Private Insurer's Perspective of Oregon's Reforms

Be Careful to Note What Has Worked — and What Has Not

By Richard Rambeck
Editor

Editor's note: Last year, Insurance-Week, *as part of our 1992 look at workers' compensation, presented the story of the turnaround at Salem, Ore.-based Saif Corp., the quasi-public non-profit entity that serves as Oregon's state workers'-comp. fund and is the state's largest workers'-comp. carrier.*

This year, in the interests of equal time and to gain a private insurer's perspective of the Oregon workers'-comp. market, we present the story of Saif's seemingly eternal and very bitter rival, Portland-based Liberty Northwest Insurance Corp., the state's largest private workers'-comp. carrier

Steve Beckham professes no desire to play the role of revisionist historian. Beckham, the manager of government affairs for Portland-based Liberty Northwest Insurance Corp., readily concedes that legislative reforms enacted during the past few years have transformed the Oregon workers'-compensation market from profoundly dysfunctional to proudly functional.

But Beckham cautions that it is necessary to read the fine print of this success story, as well as to analyze the reforms and their impacts — and what hasn't been done.

Beckham notes that the much-praised reforms of 1990, passed by the state Legislature during a one-day special session, are merely the final pieces in a puzzle of change that took several legislative sessions to complete. But the 1990 legislative package coalesced all the other reforms into a system that has drawn praise nationally and spawned the sincerest form of flattery in many states.

"We did a lot of right things, but you have to look at what we did, honestly, and ask, 'What's working and what isn't?'" Beckham says.

What's working?

✏ Oregon has had three consecutive years of double-digit percentage workers'-comp. premium decreases.

✏ The costs of vocational rehabilitation and palliative care — the relief of pain or discomfort without a true "cure" — have dropped dramatically.

✏ Beckham says the reform legislation, particularly 1990's Senate Bill 1197, has significantly increased efficiency and reduced costs by "narrowing the funnel" of what constitutes compensable claims, reducing the time injured workers spend in the system, and reducing re-entry to the system by restricting workers' rights to claim aggravated injuries.

What isn't working?

✏ Efforts to reduce medical, curative costs, according to Beckham.

Failings of SB 1197

The Liberty Northwest official leaves no doubt that one aspect of SB 1197 left him cold: a provision preventing workers'-comp. carriers from owning or having any interest in managed-care organizations (MCOs).

"MCOs in Oregon are dominated by medical-service providers, which charge us [workers'-comp. carriers] fees — and that adds to our costs," Beckham says. "That's been one of the great fallacies of the Oregon system, the effectiveness of MCOs in reducing costs."

Steve Beckham

Beckham has a warning for insurance officials from other states — and there are apparently a lot of them — who believe they would be best served by copying the Oregon system: "You have all these states cloning Oregon's MCOs, and they're cloning the wrong thing.

"There were some real accomplishments with the reform, but what worked and was appropriate for the Oregon system won't necessarily work and be appropriate in other jurisdictions."

If Liberty Northwest, which wrote $180 million in premium last year and covered 10,000 Oregon businesses with an aggregate total of 250,000 employees, has its way, the Oregon system will continue to spawn copycats.

The Wave of the Future?

Oregon has become the laboratory to test a prototype of what is

Liberty Northwest Insurance Corporation

known as 24-hour care, which combines workers'-compensation and group medical programs into one plan. The state Department of Insurance and Finance has received a grant of more than $330,000 to fund a 24-hour pilot program, which will include some yet-to-determined Oregon businesses.

Liberty is also interested in 24-hour care, but would need legislation, which undoubtedly would hinge on the success of the DIF's pilot program, to enact such a program as a private insurer.

Beckham, however, says that regardless of what the Legislature does or doesn't do regarding 24-hour care, Liberty will begin late this year integrating the administrative aspects of workers'-comp. and group health coverages for those Liberty clients that could fit under such a plan.

"It would be just an extension of what we already offer our policyholders," he says. "Many of them [employers] have asked us to do this. ... We plan to move slowly, incrementally into this combined administration function because we don't want to lose that quality service that we provide."

UnSaif at Any Speed

One thing Liberty apparently will never lose is its antipathy for Saif, to which Beckham usually refers as "the state fund." (Saif President Katherine Keene disses Liberty by calling it "Brand X.")

The two carriers have butted heads on virtually every issue, and harsh words are spoken at virtually every opportunity. "Saif denies too many claims," says Liberty. "Liberty denies too few claims," says Saif.

The facts, according to a DIF investigation last year, show that Saif is two and a half times more likely (29 percent to 12 percent) to deny a claim than is Liberty.

"We believe this report shows that the difference between our denial rate and that of other insurance companies is appropriate given the vigilant approach we have to claims management," said Brian Steffel, senior vice president and chief claims officer for Saif, after the DIF released its findings a year ago.

Said Stan Long, former Saif president and chief executive officer, who is now a cost-containment executive with AIG, "We *manage* claims, we don't *process* them."

Nothing makes Beckham's corporate blood boil more than hearing about Saif's claims process.

"I get real tired of someone saying my claims process is lousy," says Beckham, who didn't say "lousy."

"It's so preposterous. It's so off the wall. It simply cannot be true that Saif and only Saif implemented the [1990] law correctly.

"In Oregon," Beckham says, "people are saying, 'This [reform] has been a tremendous, tremendous windfall for insurers.' No. It has been a tremendous windfall for Saif."

Liberty isn't exactly hurting. The carrier has grown a hundredfold in the last decade, from a five-employee entity in 1983 to its present 500-person staff. And the company is trying to position itself to be on the cutting edge of the future — 24-hour care.

Beckham sounds optimistic about what is to come, but in the same breath, he admits of the past, "It's been quite a ride."

And quite a story. ■

EXHIBIT 6
DATE: 3/10/93
SB 347

Tough Stuff Handled Here

Umbrellas • Property Coverages
Railroad Protective • Liquor Liability
Products Liability • Environmental
and Asbestos Abatement Contractors

A+ Carriers, Limits to $5 million, Claims made.

Call Bob Stahl or Tom Sawyer today.

Independent Insurance Wholesalers

722 SW Second Ave., Suite 340, Portland, OR 97204-3130
(503) 224-1956 • Fax (503) 224-3010

EXHIBIT 1
DATE 3-10-93
~~HB~~ SB 347

Amendments to Senate Bill No. 347
Third Reading Copy

Prepared by Jacqueline Lenmark
American Insurance Association
March 10, 1993

1. Page 19.
Following: line 11
Insert: "(4) a worker whose injury is subject to the provisions of subsection (3) may procure the services of any qualified medical service provider:

(a) for emergency treatment if a treating physician in the managed care organization is not available for any reason;

(b) for conditions the worker in good faith believes are not related to the compensable injury; or

(c) when a worker living in a rural area would be unduly burdened by traveling to a managed care organization treating physician."
Renumber: subsequent subsection

2. Page 19.
Following: line 22
Insert: "(5) a worker whose injury is subject to the provisions of subsection (3) may not be required to use a managed care organization if none is established in reasonable geographic proximity to the worker's residence and the worker may choose his treating physician under the provisions of [Section 5(1) and (2).]."

3. Page 20, line 7.
Following: "organizations."
Insert: "PREFERRED PROVIDER ORGANIZATIONS ESTABLISHED UNDER THIS SECTION MUST MEET THE SAME CRITERIA AS THOSE ESTABLISHED FOR MANAGED CARE ORGANIZATIONS UNDER [SECTION 9]."

4. Page 20, line 24.
Following: "department"
Strike: "may"
Insert: "SHALL"

5. Page 21, line 2.
Following: "workers."
Insert: "insurers or self-insured employers may form groups in contracting for managed health care services with medical service providers."

6. Page 21, line 18.
Following: "providers,"
Insert: "self-insured employer or insurer,"

7. Page 21, line 24.
Following: "Montana."
Strike: the remainder of line 24 through page 22, line 3.

8. Page 23.
Following: line 13
Insert: "(b) allows a selection by the worker from more than one medical service provider in the health care specialty required for treating the specific problem of the injured worker.

EXHIBIT 7
DATE 3/10/93
SB 347

EXHIBIT 8
DATE 3-10-93
HB SB 347

Mr. Chairman & Members of the Committee

I am Tom Ebzery ~~of~~ & Billings attorney and I rise on behalf of Montana Associated Physicians Inc, a group of approximately 120 physicians ~~of~~ in Billings. My testimony is limited to language in Sec. 6 p. 20 - specifically the Harp Amendments #3 & #4 - as to who can participate in PPO Organization.

As Senator Harp has mentioned for reasons still unclear physicians & physician groups were those removed from those eligible to participate and left "clinics" in.

As a physicians group but not a clinic: MAPI wishes to participate and supports the Harp Amendments 3 & 4, which will restore physicians, hospitals, clinics, pharmacies etc. to those eligible to participate. They will be back in the bill as "medical providers" in line 5.

Senator Harp has described his desire for competition & to correct the oversight. We strongly support Amendments 3 & 4 as SB 26

EXHIBIT 9
DATE 3-10-93
HB SB 347

MONTANA OPTOMETRIC ASSOCIATION
36 SOUTH LAST CHANCE GULCH, SUITE A • HELENA, MT 59601 • TELEPHONE (406) 443-1160 • FAX (406) 443-4614

SENATE BILL 347

Mr. Chairman and Members of the Committee, for the record my name is Bruce Coen. I am an optometrist residing in Helena and am a past president and member of the Montana Optometric Association. I am appearing before you today on behalf of the Montana Optometric Association.

We support Senate Bill 347. We believe it is a good bill that addresses an important issue of worker's compensation--that is, the problem of medical cost containment.

We do have an amendment that we would like the committee to consider. The purpose of our amendment is to add "optometrist" to the definition of "treating physician", on page 10, line 17 of the bill.

We believe it is important to include optometrists as treating physicians because it is cost effective. The most common type of workers' comp injury treated by an optometrist is removal of a foreign body from the eye. Optometrist's fees range from $30 to $60 for this procedure. This is less expensive that if this same procedure is performed in a hospital emergency room or by a specialist. Most small hospitals do not even have the necessary equipment--i.e., a slit lamp--so they either then refer to an optometrist, in some cases borrow the optometrist's equipment, or use a magnifying glass (a less desirable treatment method).

Recognizing the cost effectiveness of optometric treatment, Doctors of Optometry are defined as physicians for purposes of participation in the Medicare program with respect to providing any service they are authorized to perform by state law or regulation.

We urge the Committee to pass SB 347 and respectfully request that the Committee adopt our proposed amendment.

Proposed Amendment to Senate Bill No. 347:

Page 10 - Line 17, add:

(f) an optometrist licensed by the state of Montana under Title 37, chapter 10.

EXHIBIT 10
DATE 3-10-93
HB SB 347

Tippy & McCue

ATTORNEYS AT LAW

1215 Eleventh Avenue
P.O. Box 543
Helena, Montana 59624
406·442·4448 FAX 406·442-8018

Roger Tippy
Mary Kelly McCue

March 8, 1993

Nancy Butler, General Counsel
State Compensation Mutual Insurance Fund
5 S. Last Chance Mall
Helena, Mont.

Re: SB 347 (third reading), Sec. 4

Dear Nancy,

The language of the bill is confusing to pharmacists, particularly where it amends existing subsec. (2) of code sec. 39-71-727. We must assume that pharmacies not designated as PPOs will be dispensing prescription drugs to injured workers in at least two situations: (1) at the outset of injury in all cases, before the insurer gives written notice of a PPO to the worker (page 20, lines 9-12), and (2) in those areas of the state where distance may make it impractical to designate a PPO (the "Ekalaka effect").

The immediate question is, what is the "reimbursement rate" for the generic drug which the nonpreferred provider bills the insurer? It is either the PPO's rate under subsec. (5), A.W.P. plus dispensing fee, or it is set by Labor & Industry under the schedule of fees for medical nonhospital services (page 13, lines 12-13). As the term "reimbursement rate" is not used elsewhere in the bill, other than in subsec. (5) of Sec. 4, it is reasonable to read that intent into the change to subsec. (2) of Sec. 4.

Under that reading, how would the Fund communicate the reimbursement rate to all pharmacies, so they know how much to bill for the medication? Would that be the reimbursement rate in Ekalaka and other regions without PPO designations?

Under the other interpretation, where the Department sets a schedule of fees for generic drugs under 39-71-704 (2), as it would be amended on page 13 of the bill, would that be payable to the nonpreferred pharmacy even if it was lower than the PPO's reimbursement rate? I note that the rule changes the Department held hearings on last Feb. 18 do not set any schedules for prescription drugs, noting that they are regulated under 39-71-727. How would the Department set such a schedule if that is the intent to the bill--by surveying pharmacists' usuals and customaries, or by starting from A.W.P.? Among the many areas in which a Statement of Intent (which would seem to be required for a bill like this anyway) would be helpful is this area.

Going back to PPOs and Sec. 6, pharmacists should have a concern with this sentence on page 20, lines 9-12: "After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers." Who eats the loss if the Fund tells a worker after his third refill of a prescription that he now has to go to a PPO pharmacy, but he goes back to the same nonpreferred pharmacy for his fourth and fifth refill anyway? Does the pharmacy have to ask the worker each time whether he has heard anything about a preferred provider from the Fund? What if the worker lies or doesn't receive the notice? Is the pharmacy stuck anyway?

I understand that you want to have some incentives for pharmacies to bid low on the dispensing fee in order to get the business. The bigger a share of the market they can see, the lower they'll bid the fee. It may be a dollar or two. However, the reimbursement of the nonpreferred provider is going to be very complicated under the current language of the bill, for the reasons I have noted. I would suggest the following concept: a nonpreferred pharmacy, dispensing to a worker who has been told to go to a preferred pharmacy, can only receive the A.W.P. without any dispensing fee. That would require inserting "except as provided under 39-71-727" after "providers" on page 20, line 12, and then amending 39-71-727 (2) on page 17 to extend its principle to dealing with a nonpreferred pharmacy. A new sentence something like this: "If an injured worker prefers obtaining the generic drug from a pharmacy which is not party to an agreement under [section 6] after the insurer has notified the worker to use a preferred provider pharmacy, the worker may pay directly to the pharmacist the difference between the average wholesale price of the drug and the pharmacist's retail price, and the pharmacist may only bill the insurer for the average wholesale price of the generic-name drug."

With this change we would know what reimbursement rate means, we would not have to worry about how to fit drugs into the fee schedule, and the pharmacist would not worry about getting burned in the after-PPO-notification. If this is seen as still eroding the cost-saving effects of the bill in the prescription area, I surely hope you can tell me how that would happen.

It's too bad your claims management is so far behind Medicaid's--the way to save some serious money on drug benefits is with a drug utilization review process like they are setting up. But I realize you have to tackle these things a step at a time.

Sincerely,

Roger Tippy/Montana State Pharmaceutical Assn.
cc: Sen. Harp, House Select Committee members

March 9, 1993

EXHIBIT 10
DATE 3/10/93
SB 347

Roger Tippy
Montana State Pharmaceutical Assn.
P. O. Box 543
Helena MT 59624

Re: SB 347, Section 4

Dear Roger,

Senator Harp has asked that I respond to the concerns you expressed in your letter of March 8, 1993, to Nancy Butler, General Counsel.

Section 39-71-727 (2) is an indication to the provider that the insurer is responsible only for the cost equivalent of the generic product. They should bill the A.W.P. for the generic product, and charge the claimant the difference between that and the A.W.P. for the brand name product. Then add the dispensing fee to the insurers bill.

Pharmacies know very well what the A.W.P. for products are at the time of dispensing. There is no need for the "Fund", or any other insurer, to communicate that information. The rates would be the same in Ekalaka as in any other location. The Department does not set a schedule of fees for generic or any other product. They set schedules for services, not for products. The reimbursement rates you a concerned about will be set by statute, i.e.; A.W.P. plus the dispensing fee.

It will be incumbent upon the insurer to notify the pharmacy, as well as the patient, in the event written notice is given of a preferred provider agreement with another vendor. Where the State Fund is concerned, the pharmacy would know about such agreements since we would need to do an RFP prior to establishing any preferred providers. The language you suggested is more in line with the "willing provider" concept, which Senator Harp has resisted. A drug utilization review process would be great to have, but it has nothing to do with reimbursement rates, which are addressed by this bill.

Sincerely,

P. J. Strizich
Assistant Vice President - Benefits

PJS/s
CC: John Harp
Nancy Butler

EXHIBIT 10
3/10/93
SB 347

SB 0347/02

to 39-71-605."

Section 4. Section 39-71-727, MCA, is amended to read:

"39-71-727. Payment for prescription drugs -- limitations. (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the physician specifies no substitutions or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the cost reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the cost reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the physician specified no substitutions or that the generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7 6] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

(5)(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5.** Choice of physician by worker -- change of physician -- receipt of care from managed care organization. (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed

EXHIBIT 11
DATE 3-10-93
HB SB 347

Good afternoon Mr. Chairman and members of the Committee, my name is Barbara Downing and I am from Billings. I have been a waitress for 33 years and have been employed by the Radisson Northern Hotel for the last 14 years.

Approximately a year and a half ago I fell in the kitchen at the hotel and fractured my spine. Ultimately I underwent surgery and intensive physical therapy.

During the last year that I was employed, I worked 32 hours a week and made $6018.00 in wages and $1867.00 in tips for a grand total of $7885.00. Based on that income my current weekly Workers Compensation benefit is $119.34. From this paltry sum I must pay for my own health insurance and pay cab fair to and from physical therapy and doctor appointments. Cab fair is now $9.50 one way from my house; and for a long time I was attending therapy 5 days a week.

I would like to ask you for just one moment to imagine what it is like for me to try and pay my regular monthly bills and living expenses. It is impossible. I have had to give up every luxury and cut my budget to the bare essentials. If SB 347 is passed I will then be required to take out money to help pay the medical bills. It is not fair to make me pay more when I am already trying to make it on less.

Please vote no one SB 347.

Thank you.

Barbara Downing
355 Naylor
Billings, Montana 59101

OCAW
Oil, Chemical & Atomic Workers
International Union, AFL-CIO

Dan C. Edwards
International Representative
P.O. Box 21635
Billings, MT 59104
406 / 669-3253 (Home)

EXHIBIT 12
DATE 3-10-93
HB SB 347

SB 347

Testimony of:

Dan C. Edwards, International Representative
Oil, Chemical & Atomic Workers Int'l Union, AFL-CIO
P.O. Box 21635
Billings, MT 59104 669-3253

Testifying before the House Select Committee on Workers' Compensation[1], March 10, 1993, 3:00 p.m., Room 312-3.

****

THE DEAL IS DEAD

If this Bill, and its companion bills HB 604 and HB 504, become law the historic "deal" that brought about workers' compensation programs many decades ago is dead.

Workers' compensation laws are designed to provide an equitable system for handling work related injuries, illness and disabilities. and in so-doing protect the employer from law suits from injured employees. The U.S. Department of Labor describes workers' compensation as follows:

> "Workmen's compensation was devised to assure that benefits would be paid to workers injured on the job, and that they would be paid promptly, with a minimum of legal formality, and without the necessity of fixing the blame for injury. Under laws the cost of work injuries is considered part of the cost of production."

Workers' compensation is a compromise, no-fault, system. It is not, and was not, intended to be totally satisfying to the worker or the employer. The injured worker does not receive his/her full remuneration for loss of wages, but they are entitled to immediate medical care and a percentage of their wages without delay.

---

1. Copy of this testimony will also be provided to the members of the full House Labor and Employment Relations Committee.

The devastating attack that this session of the Montana legislature has seen on workers' compensation has only one victim -- the injured worker. This unrelenting attack is truly a case of "blame the victim".

It should be obvious to everyone concerned about Montana's workers' compensation crisis, that at least one of the major reasons for our dilemma is that far too many workers are being injured on-the-job. The State and employers must promote job safety which will result in fewer accidents and ultimately lower job injury insurance premiums. Job safety is good business for the employer as well as for the employee. his/her family, and the community. SB 163 promotes this concept and should be supported.

I would like to highlight some of the major problems with the Bill before you today:

Worker "fees" and premiums: This flies in the face of the entire workers' compensation concept. Immediate medical care at the employer's expense, and paid for by employers, is the major benefit for which workers gave up the right to sue. To ask employees to now pay a portion of the costs for workplace injuries, either through fees or premiums, must not be allowed. Not one of the 50 other states allow such fees, nor does any other state require employees to pay any portion of what is legitimately and morally the employer's workers' compensation premium.

Return to the "company doctor": Despite what some would have you believe, SB 347 returns the workers' compensation program to the days of sending the employee to the "company doctor", whose interest is far more likely to be beholding to the employer who pays his/her salary than to the injured employee. Color it any way you wish, you can not get around the fact that by forcing employees to only go to medical providers with whom the insurance carrier has a "contract", is a return to company doctorism.

Deny secondary medical services to permanently "partially" disabled workers: This provision, which denies secondary medical services to the permanently "partially" disabled unless there is a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment, is simply barbaric. This would "cast out" those injured workers who may need help the most. Who decides what is "cost effective? I'll bet it's not the injured worker!

One concept of SB 347, "managed care" is supported by labor to facilitate lower costs. HB 628 provides managed care in a fair manner and should be resurrected.

Good legislation, as well as good administration, depends on sophisticated cooperation among all parties. The current wholesale attack on the working men and women of this great State, is not the way to "fix" Montana's workers' compensation problems.

In closing, I urge this select committee, and the full House Labor and Employment Relations Committee, to reject the several Bills that totally do away with the original objectives of workers' compensation. Instead, methods that promote workplace safety and reward those employers with good safety and health programs, and other programs which deal with the staggeringly high accident rate in some Montana industries, must be found. Likewise, fair "managed care" should be adopted.

Please give SB 347 a <u>do not pass</u>.

Thank you. I will be glad to answer any questions at the conclusion of the hearing. I would also be pleased to discuss this matter with any Legislator at your convenience.

######

EXHIBIT 12
DATE 3/10/93
SB 347

EXHIBIT 13
DATE 3-10-93
HB SB 347

Montana Trial Lawyers ASSOCIATION

Directors:
Wade Dahood
Director Emeritus
Monte D. Beck
Thomas J. Beers
Michael D. Cok
Michael W. Cotter
Karl J. Englund
Robert S. Fain, Jr.
Victor R. Halverson, Jr.
Gene R. Jarussi
Peter M. Meloy
John M. Morrison
Gregory S. Munro
David R. Paoli
Paul M. Warren
Michael E. Wheat

Executive Office
#1 Last Chance Gulch
Helena, Montana 59601
Tel: 443-3124

Officers:
Thomas J. Beers
President
Monte D. Beck
President-Elect
Gregory S. Munro
Vice President
Michael E. Wheat
Secretary-Treasurer
William A. Rossbach
Governor
Paul M. Warren
Governor

March 10, 1993

Rep. Chase Hibbard, Chair
House Select Committee on Workers Compensation
Room 325, State Capitol
Helena, MT 59620

RE: SB 347

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to portions of SB 347, which revises workers compensation law regarding medical benefits. MTLA opposes numerous provisions of SB 347:

1. The bill reflects an underlying assumption that current law guarantees excessive medical benefits to injured workers. That assumption is incorrect. Current law may indeed provide medical benefits to injured workers inefficiently, and MTLA supports efforts to reduce wasteful and duplicative medical services. But instead of repairing certain problems, SB 347 concludes that they are irreparable and amputates them:

* Instead of correcting mismanaged care for pain, the bill denies injured workers treatment for pain altogether unless such treatment contributes to something called "medical stability" (Section 2, page 8, lines 11-13; page 9, lines 3-11; Section 3, page 12, beginning with line 7).

* Instead of correcting mismanaged maintenance care, the bill denies virtually all maintenance care for injured workers--even those with permanent total disabilities. Injured workers will only be entitled to maintenance care "to monitor administration of prescription medication" or "to monitor the status of a prosthetic device"--if they need maintenance care to feed, dress, or otherwise care for themselves, they also need permission from the insurer (Section 3, page 12, beginning with line 7).

* Instead of correcting mismanaged domiciliary care, the bill denies injured workers important domiciliary care (Section 11, pages 25-27).

2. SB 347 requires injured workers to pay for medical treatments (i.e., Section 3, page 15, lines 5-20) without regard to their ability to pay and even when those treatments are ordered by a doctor unilaterally selected by the insurer (i.e., Section 5, pages 18-19). Apparently without a written legal opinion, and on the basis of analogies to indemnity benefits, SB 347 seeks to insert a fundamental change into Montana's workers compensation system, a change which no other state in the nation has enacted. MTLA believes that requiring injured workers to pay for medical treatments violates the underlying bargain between employers and employees and seriously jeopardizes the exclusive remedy enjoyed by employers.

3. SB 347 reflects an underlying assumption that workers compensation insurers are trustworthy and deserve virtually unlimited discretion while injured workers and their medical providers use their discretion to exploit the system. For example:

* Section 10 authorizes an insurer to terminate any compensation benefits, not just when an injured worker in fact unreasonably refuses to cooperate but also whenever the insurer believes that the worker has unreasonably refused to cooperate (page 25, line 13).

* Section 11 drastically limits the situations in which an insurer must provide domiciliary care and even then requires such care, not from the date when the claimant needs it but from the date when the insurer knows, by a "preponderance of credible medical evidence" and "with a reasonable degree of particularity," that the claimant needs it (page 25, line 24 through page 26, line 6).

* Section 12 (page 27) declares that insurers are not liable for charges by self-referring medical providers, but it neglects to extend that admittedly reasonable protection to injured workers.

MTLA urges this committee to distinguish between provisions of SB 347 which challenge inefficiencies and provisions which surrender to such inefficiencies. MTLA urges this committee to reject the latter provisions.

Thank you for considering these comments. If I can provide additional information or assistance, please contact me.

Respectfully,

Russell B. Hill

Russell B. Hill
Executive Director

EXHIBIT 13
DATE 3/10/93
SB 347

EXHIBIT 14
DATE 3-10-93
HB SB 347

Proposed Amendments to Senate Bill 347
Third Reading Bill (Blue Copy)
By: Janice S. VanRiper

1. Page 11, lines 23-24.
Leave statute as is.

2. Page 15, lines 5-20.
Strike: lines 5-20

3. Page 27, line 5.
Strike: "and the insurer is not liable for more than 8 hours of care per day.

4. Page 28, line 7.
After "The Providers", add: NEW SECTION:
NEW SECTION. Section 14. Rule Making Authority.
(1) The Department of Labor and Industry shall adopt rules as follows:
(a) Providing for timely administrative procedures for resolving disputes arising under _____, with specific provision for expedited procedures in cases of emergency; and,
(b) Assuring that claimants receive timely information regarding their rights and responsibilities under _____. This may include requirements that insurers provide certain information to claimants on forms approved by the Department.

5. NEW SECTION. Section 15. Insurers to pay claims within 30 days of receipt - exceptions - providers not to bill claimants.
(1) Upon receipt of a medical bill for a claimant, an insurer must either:
(a) Authorize the bill for payment to the State Auditor within 30 days; or,
(b) If more information is needed to determine compensability, within 14 days, issue a specific written request for the necessary information and provide a copy of the request to the claimant or health care provider, as the case may be; or
(c) Deny the bill, providing written reasons for the denial to the claimant and health care provider.

(2) Upon receipt of information as provided in (1)(b), the insurer must exercise option as provided in (1)(a) or (c).

(3) Health care providers may not bill a claimant directly for services alleged by a claimant to be covered under a workers' compensation or occupational disease claim without a written denial of liability for the bill from a claimant's workers' compensation carrier.

6. NEW SECTION:
Section 39-71-605 is repealed.

EXHIBIT 14
DATE 3/10/93
SB 347

EXHIBIT 14
DATE 3/10/93
SB 347

that occur on or after [the effective date of this act]." Effective July 1, 1991.

Cross-References
"Division" defined, 39-71-116.
"Insurer" defined, 39-71-116.
"Physician" defined, 39-71-116.
"Injury" or "injured" defined, 39-71-119.

39-71-605. Examination of employee by physician — effect of refusal to submit to examination — report and testimony of physician — cost. (1) (a) Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, he shall, upon the written request of the insurer, submit from time to time to examination by a physician or panel of physicians, who shall be provided and paid for by such insurer, and shall likewise submit to examination from time to time by any physician or panel of physicians selected by the department.

(b) The request or order for such examination shall fix a time and place for the examination, with regard for the employee's convenience, his physical condition, and his ability to attend at the time and place that is as close to the employee's residence as is practical. The employee shall be entitled to have a physician present at any such examination. So long as the employee, after such written request, shall fail or refuse to submit to such examination or shall in any way obstruct the same, his right to compensation shall be suspended. Any physician or panel of physicians employed by the insurer or the department who shall make or be present at any such examination may be required to testify as to the results thereof.

(2) In the event of a dispute concerning the physical condition of a claimant or the cause or causes of the injury or disability, if any, the department, at the request of the claimant or insurer, as the case may be, shall require the claimant to submit to such examination as it may deem desirable by a physician or panel of physicians within the state or elsewhere who have had adequate and substantial experience in the particular field of medicine concerned with the matters presented by the dispute. The physician or panel of physicians making the examination shall file a written report of findings with the claimant and insurer for their use in the determination of the controversy involved. The requesting party shall pay the physician or panel of physicians for the examination.

(3) This section does not apply to impairment evaluations provided for in 39-71-711.

History: (1)En. Sec. 13, Ch. 96, L. 1915; re-en. Sec. 2906, R.C.M. 1921; re-en. Sec. 2906, R.C.M. 1935; amd. Sec. 16, Ch. 23, L. 1975; Sec. 92-609, R.C.M. 1947; (2)En. Sec. 10, Ch. 234, L. 1957; amd. Sec. 27, Ch. 23, L. 1975; Sec. 92-814.1, R.C.M. 1947; R.C.M. 1947, 92-609, 92-814.1; amd. Sec. 1, Ch. 422, L. 1985; amd. Sec. 15, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 5, Ch. 558, L. 1991.

Compiler's Comments

1991 Amendment: In (1)(b), at end of first sentence, provided that place of examination be "as close to the employee's residence as is practical"; in (2), in second to last sentence, substituted "claimant and insurer" for "department" and in last sentence, at beginning, substituted "requesting party" for "department" and at end deleted "and shall be reimbursed by the party who requested it"; and made minor changes in style. Amendment effective July 1, 1991.

Applicability: Section 15, Ch. 558, L. 1991, provided: "[This act] applies to injuries that occur on or after [the effective date of this act]." Effective July 1, 1991.

Cross-References

Procedural rules on physical and mental exams, Rule 35, M.R.Civ.P. (see Title 25, ch. 20).

Ex. # 14A
DATE 3-10-93
SB-347

March 4, 1993

Montana Legislature
Workers Compensation Special Comittee
State Capitol
Helena, MT 59620

Chairman Hibbard and Comittee Members:

I have chosen to write to you regarding the problems with the Workers Compensation Division. I have been up to the Capitol for several of the meetings. I have listened to various press coverage as well. I think that it is time for someone to speak on behalf of the claimant. I think it's about time for you to hear what really goes on with the comp. system from someone who's been drug through it.

I am a former claimant. In fact, I have two claims filed on me, and both were filed with one employer. The first was for bilateral carpal tunnel and the second for a severe back injury. Both claims resulted in surgeries. My comp carrier was also through a third party insurance company. I had no idea of what sort of fiasco I was in for.

I was diagnosed with carpal tunnel in December of 1985. My physician instructed me to have my employer file an industrial accident claim because he was going to send the bill to comp. This is where I encountered the start of my battle. My employer refused to file a claim. It didn't seem to matter that my doctor had recommended this. This left me having to go up to Workers Comp. after work that afternoon and file my own claim. At least I knew then that my employer would have no alternative but to fill out a claim form.

I had the first surgery done the first week of February '86 and the second surgery 6 weeks later. I returned to work in mid April. My employer had stated to the comp carrier that I would be in a non-keying position, meaning I would not be doing any data entry. This was hardly the case. I spent only a half hour a day not keying. The rest of my time was spent on the computer.

I made a complaint to my claims adjuster regarding the false statement of my employer as to my job description. My claims adjuster supposedly went to my work place to see what my job entailed. I found this to be very interesting since she never came there while I was working. Since I was the only one doing the job I had, I would think that she would have come there when I was working. How else are you really going to know what a claimant is doing at their job?

Within six months of my having surgeries, seven other people in our

data entry group were diagnosed with carpal tunnel. Since there were only ten data entry personnel to begin with, that meant 80% were all diagnosed with the same thing. We also had two of the three people in the mail room with the same diagnosis.

The management of our office always seemed to blame these problems on the employees instead of where the blame should be--with the management. The company bought everything cheaply. They never once took care as to whether or not the work stations would be adequate for the type of work being done. To this company, the only thing that was important was that we made them money.

When I injured my back in August of 1987, it was due to direct negligence of my employer. I had tripped in a hole in the middle of the hallway that had been there for the entire two and a half years that we had been in business. The hole was an old floor safe from the previous tenant. It was approximately 6 inches in diameter and 1 1/2 to 2 inches deep. When our company took over the building and remodeled, instead of leveling the hole, they laid the carpet down in it. I was not the first to trip in it, and many complaints had been made over sprained ankles. However, I was hurt the worst.

I didn't really think I had hurt myself, until I tried to stand up. The pain felt like someone had just poured gas on my back and lit a match. I reported what had happened 30 minutes before, to my immediate supervisor. I left work and tried to get into the orthopaedic clinic. I was informed that they were not taking any comp claims until October. This was the 24th of August. There was no way in hell I could sit around in the shape I was in for 2 months. They recommended that I contact my family doctor.

I saw the family doctor late that afternoon. He ran a series of x-rays, put me on a bunch of drugs, and recommended bed rest for the next 10 days. During my confinement to bed, I decided to call my claims adjuster to make sure the claim had been filed. That's when I discovered that no one seemed to know who was going to pay for this. Apparently my employer had been dropped by the previous comp carrier due to high risk. There seemed to be an uncertainty as to who had the coverage when I was injured.

After the completion of bed rest, it was off to physical therapy, 5 days a week; an intensive back class, 5 days a week; and seeing the doctor, once a week. This wonderful lifestyle went on for nine weeks. It was time to see if I could tollerate going back to work. Still I had no word as to what was happening with the comp end of things and I was getting highly annoyed with the claims adjuster and my employer. It had been nine weeks since I'd had a pay check. It seemed like no one cared that I had bills to pay each month.

EXHIBIT #14-A
DATE 3-10-93
SB-347

I returned to work for only 2 hours a day. I still continued to see the doctor, now every 2 weeks; and physical therapy still 5 days a week. After 3 months of this routine, I asked my doctor to have a CT-Scan done on my low back. He was insistant that I was only suffering from a lumbar strain and didn't feel the CT-Scan was necessary. I was insistant that I had injured a disk. But what do I know? I'm not the one with an "M.D." after my name.

This ridiculous vicious circle continued for 16 months. Several more times I begged the doctor to run a CT-Scan and still he denied me until I had a relaps in January '89. It still took me an act of God to get this guy to run a simple test. I had to make him mad before I finally got what I wanted. A test that could have saved the insurance company probably $20,000+ in that 16 months. The scan proved what I had been trying to tell him all along. I made him immediately refer me to someone who could help me. He referred me to one of the local orthopaedics.

I had surgery a month and a half later for a herniated disk. I was looking at a minimum healing time of six months. I was now entering the orthopaedic twilight zone!

I was still battling with my comp carrier. I would only receive checks when the mood seemed to strike them. There would be six week stretches where I wouldn't see any money at all. Because of this I was forced into getting an attorney to preserve my rights.

I ended up receiving the same circle jerk from the orthopaedic as I had from the previous doctor. There are specific things I told this doctor that never made it into my records, however they can be verified by the notes and records kept by my physical therapist.

One month post-op I had my first visit with the orthopod. I explained to him that the pain I had been previously experiencing on the left side was now appearing on my right. This was a concern to me since I was under the impression that I would be just fine after having the surgery. I was told that it was probably scar tissue and nothing to worry about. I was sent to physical therapy where they tore the adhesions.

Six months later, the symptoms had continued to increase. Again, I continued to express this concern to the orthopod. I asked him to run a CT-Scan or MRI to see what was happening. Once again I was informed that this was not necessary...it was probably just the bones compressing and there's nothing that can be done for that except eventually a spinal fussion.

In November of '90, my comp carrier sent me to one of their doctors for an evaluation because I was still unable to return to work.

The only good thing that came about from this was the fact that their doctor would not do an evaluation until he had current tests and ordered a CT-Scan. The scan showed there were postoperative changes suggestive of a recurrent disk. It also showed a buldge on the disk above. I had received a copy of the report the day after I had the test done. It took the comp doctor 2 weeks to get back to me. When he finally did, he left a message on my phone machine stating the exact opposite of what the report said. He stated that there were no signs of a recurrent disk or buldges on any other disk. This is the type of B.S. that requires claimants to seek out an attorney. I find it very interesting that when my attorney phoned him and asked how he came to his conclusion, because the report clearly states something different, he stated he read CT-Scans differently than anyone else. I invite you to figure that one out. I also find it very interesting that this doctor left town just a few weeks later.

I could go on and on with this, since this kind of garbage continued until I finally settled out in mid '92. I wanted to give you some kind of background as to what is really going on out in the world of Workers Compensation.

I am sick to death of hearing that the claimant is the one ruining the system. I'm here to say that we are not. The biggest rapers of the system are the medical professionals. The biggest offenders are certain employers across this state.

The only way to fix the system is to start where it begins-the work place. Because of the scarcity of jobs in this state, places are getting away with horrendous conditions. The place where I sustained my injuries ran like a data entry sweat shop.

I think the fact that the employer has three choices of how he wishes to insure, is a bad move. You could keep better track of things if everyone paid into the state fund and this would hopefully generate more revenues for investing. My former employer is on their 4th or 5th comp insurer. They are habitual. There has never been an investigation into this company. This is something the Dept. of Labor & Industry should be investigating and doing something about. There should be some stiff fines implemented on companies like this. Infact the best remedy would be to make them have to cover the injured themselves. If an employer is someone who has 40% of their employees injured, they should pay. In otherwords, they would be paying as if the employee was still there. Granted this is reaching to conceive this idea. However, if it happened once or twice, you might see the working environment improve. If the work place is improved and conditions are better, you have happier employees. You also have less injuries. Less injuries mean a more stable comp fund.

EXHIBIT #14-A
DATE 3-10-93
SB-347

There has got to be a data base system implemented between Labor & Industry and Work Comp. I must say that I am appalled at the fact that there isn't one. How can Labor & Industry and the Work Comp. Div. keep track of anything? There is no need to farm our comp problem out to some private entity. We have the resources here to fix it. We just need to improve the way things are currently done. We would be much better off spending a few million on a data base rather than spend 34.5 million to pay a private entity to take over the problem with no guarantee that they can do any better or even correct the problem. Where is the justification to farm it out? We hosed it up, I think it's time we fix our own problems. Let the others get rich off of someone else.

We need to generate funds, but you're not generating them by cutting benefits to the injured workers. A watch dog system has got to be set up. There needs to be claims people that know what they are doing and have some idea of as to what kind of testing needs to be done for various injuries. Your best bet in that area would be to hire former claimants. There isn't anyone of us that have suffered a 'real' injury that doesn't know every symptom there is to it and how it feels. Who better qualified where claimant fraud is suspected. Someone has got to be watching out for the injured person but not persecuting them as if all of the claimants are out to take the system on a ride. All claims should be watched and gone over with fine tooth combs for at least the first six months.

The 30 day limit recommended in a HB 628 for head or multiple injuries, just isn't a realistic call. You cannot expect the doctors to give a 10% impairment within a 30 day period. That could be disastrous for the claimant. My back was a multiple injury. It took 9 weeks for things to settle down and the pain to centralize. It wouldn't have been conceivably possible for my doctor to give any kind of impairment rating. Where head injuries are concerned, it would depend on the severity of the injury.

There is a definate need for a time period for treatments of injuries, placed on all doctors. If a claimant hasn't shown significant improvement within the first 3 months, then the comp system should step in and provide them with a list of names of other doctors throughout the state that specialize in their specific needs. These are not contracted medical. It would be a list of anyone and everyone. This would be for a mandatory second opinion. You would be saving the system and any other insurers some great costs. You are also still giving the claimant his freedom of choosing another doctor. That is a right that cannot be taken away. It would be different if we lived in an area where we had many superior medical professionals. Unfortunately, in Montana, that's just not the case. Instead there is too much

motivation by money.

I listened to a neuro-surgeon from Great Falls testify that claimants do nothing but basically bounce from one doctor to another. Or they request tests that he felt weren't necessary. This just is not true. Until these doctors have to live with the pain and in your body, they have no right to tell you that if you request something specifically, that they feel it's not necessary. Diagnostics are an important part to any injury or illness. If you don't do the proper testing, then you never know what the real problem is. This is just another example of how the doctors are in the pockets of the insurers. They don't want to run any tests yet they don't want to turn you loose either.

You have to pull teeth to get the authorization for a second opinion especially where the third party carriers are concerned. Sometimes it may take 5 or 6 doctors before you find one that is competent and truly wants to help you get better. As the consumer, the patient has the right to be treated with respect. They should not be treated like they have no idea of what they are talking about simply because they don't hold a degree in medicine. If you aren't getting better and you get nowhere with a doctor, you should be able to seek another doctor's opinion without all the hassle.

By making a second opinion mandatory, you are beginning the process of taking the medical field out of the pocket of insurance companies. There would really be no need for a comp evaluations which, for the most part, are a joke. An example is stated previously with what I went through where the doctor lied to me outright. The concern for the well-being of the claimant seems to go out the window. Getting the injured person back to work as soon as possible is good in theory but not always practical.

If you let the claimant go for a six month period, he has been tagged as a chronic pain person. It doesn't matter that the claimant hasn't been correctly diagnosed, as in my case. There is a stigma that follows anyone tagged as chronic pain. You suddenly get treated like the pain is all in your head. No one seems to take your problems seriously at this point.

There definately should be some price standards set for the medical field. They seem to go crazy where comp is concerned. An example is billing for procedures that weren't performed. When I received the bill from my back surgery, I was charged for physical therapy which I never received. There were also durable medical goods that were billed that I never received or used. Or they prescribe various anti-inflammitories or physical therapy which hasn't done any good in the past. So why keep prescribing it? These bills need to be scrutenized before they are ever paid and if something

EXHIBIT #14-A
DATE 3-10-93
SB-347

looks questionable, then ask, don't just send a check. Track those files with procedures that have been done before or appear questionable. Talk to the claimant. Find out first hand how the treatment is really going. You won't know until that claimant is contacted. Follow up with those claimants!

I also don't agree with a co-payment for the claimant. Some people, infact most, don't make enough money on comp to pay for the basics, muchless have the money to be paying a co-payment. How can you justify a co-payment to someone who's hurt because of their employer? Would you want to pay for something that you are not liable for and you wouldn't be incurring the bills from if it hadn't been for someone else? You cannot continue to victimize the injured worker. The financial stress that you incur when out on an injury is a tremendous one. Why add another burden to the injured worker?

Also, if a claimant has a long-term injury and it looks like they will not be able to re-enter the work force, there needs to be steps made to get them of the comp system and on to disability or SSI. Especially where there are severe injuries. Why keep dragging them through the state system when there are federal programs out there for this purpose? If it's a permanent injury, comp should be willing to help assist these people in other programs. Get them off of a system that was not designed to support people for the rest of their lives.

If the claimant has a long-term injury and they have future problems concerning the injury, the "pat" response from the comp carrier is always the same. Instead of taking the responsibility for the problems or changes, the carriers always try to claim it's a 'new' injury instead of it being changes from the old injury. This is a most frustrating battle. This is something I have been dealing with since my back surgery. It doesn't seem to matter that I have medical tests that state 'post-surgical changes.' That's not a new injury, it's a problem with the old. Somewhere, someone has got to be out there helping the claimant to avoid this kind of run around.
There needs to be an advocate for the injured worker.

Another misconception that needs to be gotten rid of, is the idea that the claimant is getting rich off the system. This may have been true 10 years ago, but since the changes in 1987, this just is not the case. I didn't even recover 50% of my lost wages. I couldn't even pursue my employer because my right to sue him for negligence was taken away from me due to changes in the comp laws. My injuries, especially my back, have cost me personally, a tremendous amount of money and a certain quality of life.

They say that if an injured person hasn't returned to work within

2 years, he probably never will. I think this is a very discouraging statement. I have been off of work for 4 years. I'm only 34 years old and hardly ready to throw in the towel or be a non-productive part of society. For the long-term injured who have the want and need to go back to work, there needs to be something set up for them that rebuilds ones self-esteem for starters. That's the biggest obsticle to overcome when you have been out of the work force for so long. Self confidence needs to be built back up before you can even consider any kind of retraining program. It's bad enough that your skills have been on hold for a long length of time. It's an intimidating feeling going back out into the world. You cannot just cut someone off of the system and throw them to the wolves.

Alot of claimants aren't aware of the fact that the are specific programs available to retrain them or send them to school. It's obvious that not all comp carriers care to pass this information along. This is information that should be given to all injured persons at the time of their injuries. This way, there is no chance of misinforming or not informing the claimant at all, as to the options available.

A critical change that needs to be amended in the current laws is the status of carpal tunnel. I would like someone to explain to me how you can legally call this ever increasing problem a 'job disease' instead of an industrial accident. A disease is something that attacks a part of a system in the body or an organ. Carpal tunnel is something caused by repetitive work. It is a build-up of scar tissue on the nreves in one's hands and wrists. It is not and never has been a disease.

There should be a comittee set up to oversee the entire system. However, it should not be comprised of just administration and medical professionals. There needs to be direct imput from past and present claimants. A comittee or board made up of a Wk Comp, Dept. of Labor and Industry, Dept. of Justice, medical professionals (only in the capacity of review and consulting), and claimants. All the involved entities need to work together--not seperately.

These are just a few of the things I have seen and lived through and some of the ideas I have had for several years now. I have tried to give you examples of severe abuse to the system which is totalling big money every single day. I wanted to make you aware of the fact that the claimant isn't the dog stealing the bone here. Your "I don't care" employers and the medical profession are. Yes, attorneys are also getting rich. But until something is done to correct this program in particularly things like getting paid benefits on time and getting second opinions, the need to retain an

EXHIBIT #14-A
DATE 3-10-93
SB-347

attorney will always be there.

I want to especially thank Reps. Hibbard, Driscoll and Cocchiarella, who have taken time out previously, to speak with me personally. I appreciate the fact that you listened to what I was telling you. I thank all of the comittee for taking the time to read this lengthy letter. Be thankful there are people out there like me, that do have the best interests of this situation at heart and take the time to become involved with it. Sad thing is, there aren't enough of us. I do however, appreciate all that you are trying to do and wish you all the best of luck in trying to solve this problem.

Sincerely,

Roxianne Verworn

Roxianne Verworn
1239 Boulder Ave.
Helena, MT 59601
406)442-8048

EXHIBIT 15
DATE 3-10-93
HB SB 347

SB 347 -- Testimony 3/10/93

Mr Chairman--Members of the Committee:

For the record, my name is Jerome Connolly. I am a physical therapist from Billings. Twenty one years ago I graduated from the Mayo Clinic School of Physical Therapy. I chose to return to my native state to practice my new profession. Subsequently, I took risk and started a private practice and chose to use my education, training and expertise in rehabilitating injured workers. Work injury management is only a portion of our practice in Billings, Laurel and Red Lodge, but we have associated professionals skilled in work injury management, ergonomics, functional capacity testing, prevention of work injury, and the Americans with Disabilities Act (ADA).

SB 347 has some good concepts but is wrought with problems.

1. It is not good for the injured worker because it is abundant with language that gives the insurer excuses to deny care and terminate benefits.
2. It does not embrace aggressive case management.
3. It contains no emphasis -- nothing-- on keeping the injured worker on the job.
4. It contains some pitfalls that if not corrected will actually cost insurers (State) more instead of saving money.
5. It does nothing to improve the administration and management of the State Fund which many providers, employers and workers and even legislators agree is the crux of our work comp woes in MT.
6. It eliminates PPPTs--self employed business people

See Algorithm I -- SB 347 -- Blue Bill

Connelly (2)
SB347

Physical therapy is performed upon physician referral in worker's compensation cases. This bill requires all referrals to go to the managed care organization (MCO). Since self employed PTs are not likely to be invited into a hospital or clinic MCO (competition), the bill in effect prevents us from doing work injury management--years of education, training, experience not to mention investment down the drain. The IRONY? Private PTs are lower cost provider than hospitals. (E.g Rx @ FPT $65 brings $103 at Billings Deaconess Hospital).

The second algorithm depicts PTs amendments and offers a system that allows the private PTs some ***LIMITED*** participation. Not full participation--if we were asking for FULL participation we would be asking for treating physician status which would solve the whole problem. But we are not asking for that.

The changes we offer will create a better system for the insurer and injured worker alike. No insurer control is sacrificed in fact more is interposed. A much more conventional managed care system (one with an established track record in MT) will result.

Amendment 1 proposes an addition to page 18, line 24 of the blue bill. This language is taken from the Coalition for Worker's Compensation System Improvement (CWCSI) Report of the Medical Committee adopted on 12/17/92. It has been slightly modified to require referral of treating physician and allows physical therapy treatment of 12 visits or 30 days which ever occurs first. This enables early intervention to keep the injured worker on the job. It is important to note that this physician referral is not required by any other law in the state of MT. And this proposal allows the PTs limited involvement.

EXHIBIT 15
DATE 3/10/93
SB 347

By the way, the motion to accept the Coalition Medical Committee report which contained this concept and language was made by the senate sponsor of SB 347, Senator Harp.

Through my personal involvement in the Coalition and the Billings Chamber of Commerce Work Comp task force, I recognize this bill as being important for work comp reform.

However, it falls far short, in my estimation, of accomplishing meaningful reform and without substantial revision, I just can't support it and would ask that the committee not either.

Thank you for allowing me the opportunity to share my views.

EXHIBIT 15
DATE 3/10/93
SB 347

EXHIBIT 15
DATE 3/10/93
SB 347

SB 347 -- Blue

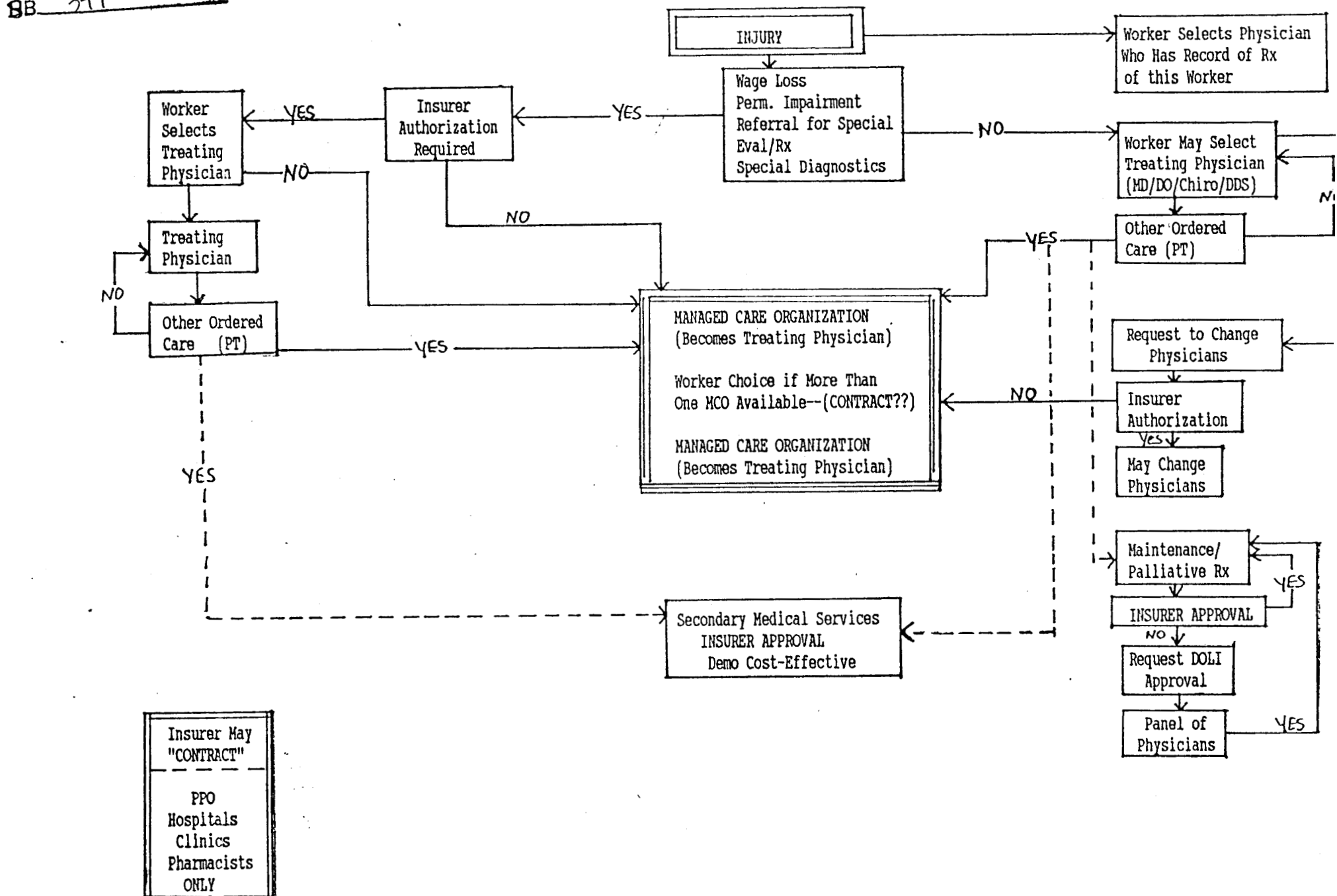
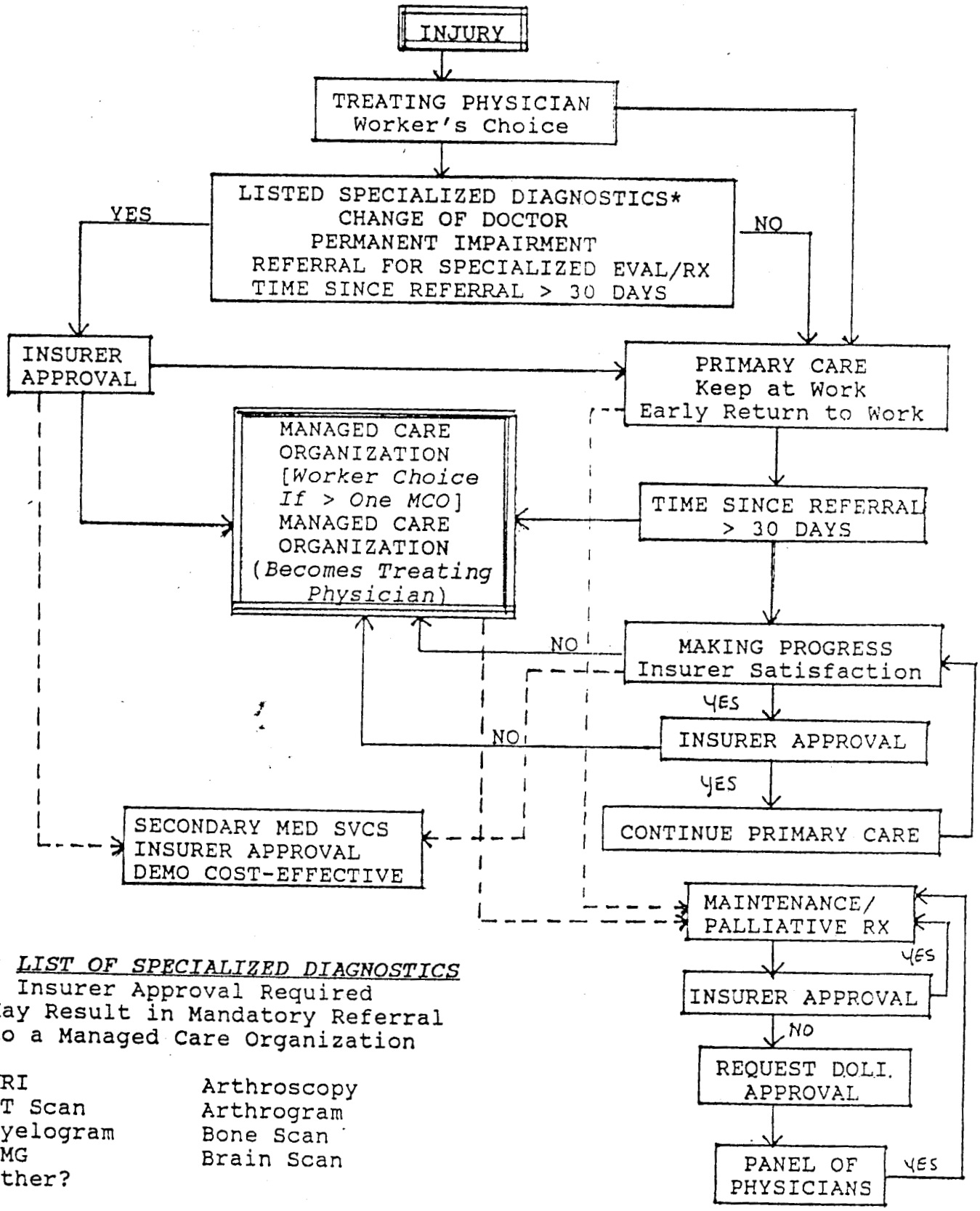


EXHIBIT 15
3/10/93

SB 347
Work Injury Management Algorithm
Physical Therapist Amendments



* *LIST OF SPECIALIZED DIAGNOSTICS*
Insurer Approval Required
May Result in Mandatory Referral
to a Managed Care Organization

MRI	Arthroscopy
CT Scan	Arthrogram
Myelogram	Bone Scan
EMG	Brain Scan
Other?	

EXHIBIT 16
DATE 3-10-93
HB 347

MONTANA CHAPTER
OF THE
AMERICAN PHYSICAL THERAPY ASSOCIATION

TO: House Select Workers Compensation Committee
Hearing - March 10, 1993

RE: SENATE BILL 347 (blue)

BY: Gary Lusin, MS,ATC,PT

I have two specific points to make on Senate Bill 347. These points will be included in the package of amendments submitted by the Montana Chapter of the American Physical Therapy Association.

1: Amendment 3 of the amendment package proposes a change on page 24, section 9 (4) (f), line 12 where specific reference is made to physical therapy. As it reads it attaches physical therapy to specialized treatment. Physical therapy has been identified as being a primary medical service as defined earlier in the bill. There is no definition in this language indicating what specialized treatment is. It seems very unusual to me that physical therapy would be singled out as the example of specialized treatment within this language.

This proposed language is another clear example of how self-employed physical therapists or even perhaps physical therapists working in a hospital that is not part of a managed care organization has been excluded from the opportunity to provide care to injured workers.

The phrase "including physical therapy" is totally unnecessary and I submit should not be considered a form of specialized treatment and this language should be deleted.

2: Amendment 2 on your amendment's sheet proposes a change on page 21, line 2. The amendment we are proposing clarifies an amendment already made in the Senate which indicates "a worker who is subject to managed care may chose from managed care organizations in the worker's community that have a contract with the insurer

responsible for the worker's medical services". The language we are proposing clarifies that if there is more than one certified MCO in the area that those certified MCO's also have full opportunity to have a contract with the insurer.

The language we are proposing clarifies that the so called contract between the insurer and MCO is not intended to be an exclusive contract thus allowing for not only the certification of more than one managed care organization in an area but the contracting of different managed care organizations within the same area.

Thank you for your serious consideration of these amendments.

EXHIBIT 16
DATE 3/10/93
SB 347

GENERAL REMARKS ABOUT SENATE BILL 347

Presented by

Gary Lusin, MS, ATC, PT

Physical therapists of this state are on record as supporting the concept of managed care. Managed care literally can take many many forms. I have read Senate Bill 347 very closely many times and have also been studying and trying to learn exactly what managed care is.

I believe there are some fundamental questions that all of us need to ask ourselves as we look to create a managed care system for Worker's Compensation in this state.

1: What do we all know individually, or as a group, about what managed care really is?

2: Can we individually, or as a group, make the critical decision as to what is good managed care language and what is bad managed care language? There are many many examples of failed managed care attempts across this country and there are also a few examples of relatively effective managed care organizations so what makes the difference between those organizations?

3: Who is the primary author both in concept and written design of this language? Is it for the most part the same people that have been writing Worker's Compensation Law for the past several years? Does the plan before us, even if amended, provide the highest possible guarantee that this state will have an effective and efficient, and dynamic, managed care system?

4: Are we attempting to pass managed care legislation simply for the sake of having a managed care law or are we trying to create a managed care system that has the best opportunity to first provide good management of care to injured workers and also to provide that care in the most cost effective manner possible?

5: Where in this language does it indicate what the responsibilities are of the insurers in actually <u>managing the care of injured workers?</u>

6: Who and how will fund the necessary computer software, personnel, and training to establish all that is necessary in an effective managed care organization?

Many, many questions need to be asked regarding managed care. There are too many examples of failed managed care organization attempts that we must learn from and not repeat those mistakes.

I would like to read some brief statements from at least one book available by experts in managed care. I present this in the sincere effort to help develop a good managed care system and not one that is designed around the "good old boy network" which in effect is doomed to fail.

I hope that these comments will challenge everyone's thinking so that we critically analyze exactly what it is we are creating with a managed care organization as it is written in Senate Bill 347 but perhaps more importantly how, why, and for whom it is being written.

EXHIBIT 17
DATE 3-10-93
SB 347

Montana Association
of Private Practice
Physical Therapists

March 8, 1993

Representative Chase Hibbard, Chair
Select Worker's Comp Subcommittee
Capitol Station
Helena, Mt 59620

Re: SB 347

Dear Representative Hibbard,

I am writing to share with you how SB 347 will impact the self employed physical therapists in this state. In its present form, SB 347 will not allow self employed physical therapists to treat injured workers at all. This will result in these small businesses going under.

Senate bill 347 accomplishes this by setting up managed care organizations around hospitals and large multi-specialty clinics. The MCO's are given exclusive control of where, when and who the injured worker sees for medical treatment. Since the hospital and clinic based MCO's have their own physical therapists will be completely left out of the care of the injured worker.

Self-employed physical therapists are small business owners. Our fees are demonstrably lower than either hospitals or large clinics. All treatment of injured workers is done on physician referral only. This bill will require referral to the MCO for treatment. This will produce a monopoly on health care provided to Montana's injured workers. The MCO's are set up to be both the gatekeeper and the provider. This situation defeats both the cost control/ utilization and quality maintenance objectives of the bill.

We fully support cost containment and the principles of managed care. What I object to is the hospitals and large clinics being set up to corner the health care market to injured workers. Yes, we need utilization guidelines. Yes, we need treatment parameters. Yes, we need uniform reimbursement controls. But we don't need the conflict of interest position this bill encourages hospitals and large clinics to take. Studies in California and Florida Worker's Comp Systems show that when there is a financial interest in a facility by the gatekeeper, both cost and utilization of services goes up.

Also please delete the section requiring a $10.00 co-pay each time an injured worker visits a provider. How is a worker making only two thirds of regular pay expected to bear this burden as well? It will only result in treatment delays and inadequacies and therefore defeats the purpose of getting the worker back to work as soon as possible.

Sincerely,

Kirk Hanson P.T.

Kirk Hanson, P.T.
143 Hawthorne
Helena MT 59601

EXHIBIT 18
DATE 3-10-93
HB SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB 347 NUMBER

MOTION: Benedict Move to Concur with amendment Sen. Bishop - (Hold pending March 10th) Carried -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 19
DATE 3/10/93
~~HB~~ SB 347

Amendments to Senate Bill No. 347
Third Reading Copy

For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Page 11, lines 12 through 15.
Strike: subsection (b) in its entirety
Renumber: subsequent subsections

2. Page 12, line 19.
Strike: "(1)(f)"
Insert: "(1)(e)"

3. Page 15, lines 5 through 24.
Strike: subsection (7) in its entirety

4. Page 18, line 15.
Strike: "subsection"
Insert: "subsections"
Following: "(3)"
Insert: "and (4)"

5. Page 19, line 2.
Following: "the"
Strike: "insurer"
Insert: "department"

6. Page 19, line 12.
Following: line 11
Insert: "(4) A medical service provider who is not a member of a managed care organization and who is not qualified to be a treating physician may provide services to the injured worker for 30 days from the date of referral or for 12 visits, whichever occurs first, with the authorization of a treating physician. Thereafter, medical services provided to an injured worker without the written authorization of the insurer are not compensable."
Renumber: subsequent subsection

7. Page 19, line 12.
Strike: "A"
Insert: "Except as provided in subsection (4), a"

8. Page 20, lines 7 through 9.
Following: "organizations."
Strike: the remainder of line 7 through "organizations." on line 9
Insert: "A preferred provider arrangement with a hospital, clinic, or treating physician may not include physical therapy services."

9. Page 21, lines 5 and 6.

Following: "HAVE" on line 5
Strike: the remainder of lines 5 and 6
Insert: "been certified by the department. Subsequent referrals must be approved by the insurer. A dispute between the claimant and the insurer regarding subsequent referrals must be resolved through the process provided by the department."

10. Page 21, line 17.
Strike: ","
Insert: "or"

11. Page 21, lines 18 and 19.
Following: "providers" on line 18
Strike: the remainder of line 18 through "organization" on line 19

12. Page 23, lines 6 and 7.
Following: "providers"
Strike: the remainder of line 6 through "organization" on line 7

13. Page 24, line 12.
Strike: ", including physical therapy,"

14. Page 25, line 1.
Following: "provider"
Strike: ", a group of medical service providers,"

15. Page 27, lines 9 through 11.
Following: "facility"
Strike: the remainder of line 9 through "services" on page 11
Following: "has"
Strike: "an investment"
Insert: "a financial"

16. Page 27, line 16.
Following: "."
Insert: "This prohibition is not intended to prevent treating physicians from providing diagnostic services in their offices."

EXHIBIT 20
DATE 3-10-93
HB SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB-347 NUMBER

MOTION: Benedict - I Move DO Concur As Amended -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN	✓	
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT	✓	
ERNEST BERGSAGEL	✓	
VICKI COCCHIARELLA		✓
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

EXHIBIT 21
DATE 3-10-93
HB SB 347

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL VOTE

DATE 3-10-93 BILL NO. SB 347 NUMBER _____

MOTION: Jensen Fix Amendments - Rep. Driscoll moved. Fails - 3-3 vote -

NAME	AYE	NO
CHASE HIBBARD, CHAIRMAN		✓
JERRY DRISCOLL, VICE CHAIRMAN	✓	
STEVE BENEDICT		✓
ERNEST BERGSAGEL		✓
VICKI COCCHIARELLA	✓	
DAVID EWER	✓	

HR:1993
wp:rlclvote.man

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) SEN. HARP

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Gail Wheatley	MT Phys Ther. Assoc		✓
Ruley Johnson	NFIB	X	
Rich Hill	Gov. Office	X	
Dorothy Bisera	DOLI		✓
Chuck Hunter	DOLI	X	
Wm Egan	MT Coop Elect Wkrs	Amend	
Lenore Ranstad	MT. Med Assn	X	
Tom Ebzery	MT Associated Physicians Inc	X	
Russ Ritty	Wash Corp	✓	
Keith L. Olson	MT. Logging Assn	✓	
Don Allen	~~MT Trial Lawyers~~	✓	
Russell S Hill	MT Trial Lawyers		✓
Michael S. Mizenko	MT. St. Assc Plumbers & Pipefitters MT. St. Bldg. Const. Council		✓
DeLores Mills	St. Employee		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GARY Lusin	Physical Therapists		X
Jay Rathman	Coalition for Workers Compensation Improvement	X	
Jim Fritzwiler	MT. CHAMBER	✓	
Lorin Wright	Physical Therapists		✓
George Wood	Mt Self Insurers Assn	✓	
MIKE MICONE	MMCA	✓	
Charles R. Brooks	MT. Retail Assoc	✓	
Samuel T. Hubbard	Deaconess Medical Center of Billings	✓	
Richard Smith	Montana Chapter American Physical Therapy Association		✓
Clarice Landry	Valley P.T.		✓
Veronica Brown	H.ERA St Council		✓
Alan Cole	MMIA-MACO-MSCIA	✓	
Ole Kennedy	MT Oper. Assn	✓	
Dan Shea	Interested Citizen		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Select Workers Comp. COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
PETE STRZICH	STATE FUND	✓	
Mona Jamison	MT. PT Assoc.		✓
Doug Judge	MT STATE AFL-CIO		✓
Rick Hull	Gov. Office	✓	
Darrell Stuver			✓
[redacted]	[redacted]		
Roger Tippy	Mt State Pharmaceutical Assn		(sort of)

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) Harp

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Terry Mutton Gt. Falls	Coalition for WC System Improvement	✓	
KIRK HANSON	MAPP		✓
Bill Cervello	Reliable Assn + Crawford + Co	✓	
Dan Van Riper	Self		✓
DAN C EDWARDS	O.C.B.W.		✓
JERRY CONVOLLY	MT Chapter American Physical Therapy Assn		✓
Joyce Dougan	Valley Physical Therapy		✓
BARBARA DOWNING	BLGS mt.		✓
HARLee Thompson	MBIA	X	
Bruce Coen	Montana Osteopathic Association	X	
Bob Olsen	MT. Hospital Assoc.	X	
Dan Lamm	Asst. Dir. Mt Chapter Phys. Therapy Assn		✓
Carlon Torgerson	Mont. Stockgrowers Assn Mont Wool Growers Assn	X	
Jacqueline Pinkmark	Am. Phys. Assoc.	✓ w/ amdts	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Select Workers Comp COMMITTEE BILL NO. SB 347

DATE March 10, 1993 SPONSOR(S) Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Carrie Gajdosik Missoula	Physical Therapist		✓ unless amended

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

opened the hearing by handing out an outline of the bills to be presented and the order of their presentation. **EXHIBIT #1** He told the committee and the audience that the intent of the Workers' Compensation Select Committee was to have a non-partisan committee with three republicans and three democrats. He stated that everyone gives including employers and insurers. The package includes provisions for fraud, safety and a data base for lawyers and medical providers. The intent of this package of bills is to provide solutions to today's problems. He presented the committee with a outline for the major areas of reform **(EXHIBIT #2)**

HB 361

REP. HIBBARD stated that this bill contains key components to reform benefits and medical definitions under workers' compensation laws. This bill was modeled after a similar bill in Oregon state. The focus of HB 361 is access of benefits, rather than reduction. Furthermore, this bill redefines injury. Pain is no longer compensable. A heart attack and stroke are considered an injury. Benefits are only paid if the major contributing factor is due to the injury. For example, if alcohol and drugs are the major contributing factor, that individual is not covered or compensable.

HB 622

REP. HIBBARD stated that this bill is a catch all bill. The intent of this bill is to encourage early return to work and to create temporary partial benefits. Medical benefits are available to the worker unless these benefits are not used for a period of 60 months.

SB 347

REP. HIBBARD stated that the intent of this bill is to deliver timely and effective care for injured workers. Submanagement care must be referred to a specialist. This bill encourages insurers to provide preferred providers. The Department of Labor plays a neutral role. Hospital rates reimburse at the same rate as Medicare, but not less than their current rates. The passage of this bill will limit domiciliary care to eight hours per day. He told the committee to consider this bill very carefully because it is essential to control medical costs.

HB 628

REP. HIBBARD stated that the intent of this bill is to provide managed care for workers' compensation and limit the choice of physicians. This bill deals with more severe injuries than HB 347. He urged the committee to consider not implementing this bill.

George Wood, Executive Secretary of the Montana Self Insurance Association, stated that his organization is opposed to HB 504 because of the payroll tax.
He stated his concern with HB 511's cost to the Department of Labor. Furthermore, he stated that stress is a great concern in the United States, but it is hard to categorize stressful situations that will reflect on workers.

He stated that HB 622 needs to be clarified dealing with temporary partial disability benefits. Presently the way the bill is drafted, temporary partial disability claims would receive more than total disability claims.

Don Allen, Coalition of Workers' Compensation System Improvement, stated that there are 215 businesses and organizations in the coalition. Several of them felt that bringing concepts together would help resolve the workers' compensation problems. He stated that his organization does not take a stand on HB 13, but has a strong endorsement on HB's 631, 622, and SB's 163, 164, 347, and 394.

Terry Mitton, Coalition of Workers' Compensation System Improvement, stated that prescription drugs need some control. Furthermore, Montana needs to follow the national standards on managed care. She stated that injured workers want to expedite their return to work. Compliance with medical treatment is necessary. If the patients don't make their appointments, the Department won't work with them.

Pat Sweeney, State Fund, stated that his organization generally supports the entire package of bills because it gives the tools to control the costs in workers' compensation.

Mike Micone, Montana Motor Carriers, stated that rates for motorists have increased and will continue to increase to a double digit number. He proposed an amendment so that several small carriers can combine into a group to get policies as a group and receive some cost reduction. Furthermore, this may encourage private carriers also to set up policies in this state.

Riley Johnson, National Federation of Independent Businesses, stated that HB 511 needs to be researched more. Computers will save time, but cost millions.

He stated that 80 percent of his members don't want payroll tax.

He stated that he supports HB 361 and HB 622 as well as the four bill's sponsored by **SEN. HARP.**

He stated that his organization had several concerns with HB 13; however, with the amendments, they support it. His organization has a 90 percent favoritism for privatization. He stated that an amendment needs to be proposed to support the small businesses.

Russ Logan, Billings Chamber of Commerce, stated that he supports the package and understands the give and take; however, he thinks it is a necessity to make sure the new fund is financially liable in HB 504.

He stated that SB 347 excludes those in the medical community.

James Tutwiler, Chamber of Commerce, stated that he supports the following bills: HB 13 with the amendments, HB 361, HB 622, SB 163, SB 164, and SB 347.

He stated that his organization is opposed to HB 504 because of the payroll tax.

Paul Spetanka, Podiatric Medical Association, stated that his organization supports medical cost containment in HB 347 and HB 628; however, he suggested that podiatrists be considered physicians.

Charles Brooks, Montana Retail Association, stated that perception is 90 percent of reality. Currently there are 6 workers' compensation cases in the court that can't proceed with prosecution because of the poor condition they are in.

Oliver Goe, attorney, commended the select committee and their accomplishments. He stated that HB 361 clarifies who, when and where an individual will qualify for workers' compensation.

He stated that HB 622 clarifies, provides and insures employers rights under the Workers' Compensation Act.

He stated that safety is an important issue; however, his concern is with the potential costs.

He stated that SB 164 affects all insurers.

Insurers can use SB 347 as a tool to handle the increased medical costs.

He stated that he is opposed to HB 511 because it needs added clarification as to what to do with the money.

He stated that HB 628 is a good bill, but he is curious how it will fit in with SB 374.

Bill Prevella, Rehabilitation Association of Montana, stated that his organization's goal this session is to keep workers properly informed. He stated that honesty to employees will make them return to work more quickly.

Mona Jameson, PT Association, stated that her organization supports HB 13 with the proposed amendments. HB 13 will improve the operation of the State Fund.

She stated that her organization would like to see physical therapists included in the scope of the bill and placed in the health loop as a provider.

Gary Lusane, a physical therapist in Bozeman, stated that his organization supports SB 163, SB 164 and HB 511.

Jerome Connolly, Montana Chamber American Physical Therapist Association and a physical therapist in Billings, stated that he supports the package, especially HB 622 because it will return employees to work faster.

Jamey Doggett, Montana Cattlewomen, stated that her organization supports HB's 13, 511, 622, 361 and SB's 163, 164, and 394.

Jacqueline Lenmark, American Insurance Association, stated that her organization supports the package, but has a concern with SB 347 dealing with rural workers and emergency care.

Keith Olsen, Executive Officer of Montana Logging Association, stated that his organization supports Senator Harp's bills. He stated that today it is cost versus value. This package may provide a competitive advantage for Montana.

Harley Thompson, Building Industry Association, stated that his organization supports SB's 163, 164, 347 and HB's 361 and 622. He stated that they feel that this package will repair the mess that workers' compensation is in at the current time.

Mark Sonyu, Workers' Compensation System Improvement, stated that his organization supports the package.

Russ Ritter, Washington Corporation, stated that there are 3,000 employees in his company. All of these employees are covered under this system except about 800 Rail Link employees.

Sam Hubbard, Deaconess Medical Hospital in Billings, stated that his organization is in support of SB 347 because of the medical cost containment.

Bob Olsen, Montana Hospital Association, stated that his organization supports HB 511 and all of the fraud bills.

Leslie Ranch, General Well service, (EXHIBIT #4).

Tom Arvidson (EXHIBIT #5).

Edsall Construction (EXHIBIT #6).

Dolphin Harris, President of Sidney Millwork Company (EXHIBIT #7).

Ardine (Dean) Bjerke (EXHIBIT #8).

Harley Thompson, Montana Building Industry Association to the Coalition for Workers Compensation System Improvement (CWCSI), (EXHIBIT #9).

Michael Mizenko, Montana State Association of Plumbers and Pipe Fillers and Montana State Building and Construction Council, (EXHIBIT #10).

Opponents' Testimony:

Dan Edward, Oil Chemical Workers' Union, provided the committee with a handout called titled "OCAN". **(EXHIBIT #18)** He stated that not all employees who are hurt on the job are involved in fraud. Most of employees are honest and hard working. He stated that his biggest concern is with the language that provides secondary medical services on returning employees back to work. He asked who decides what is cost effective? He stated that the passage of these bills may be hurting those who need the most help.

Don Judge, Montana AFL-CIO, stated that his organization is opposed to HB's 361 and 504 and SB's 347 and 394. Furthermore, his organization supports HB's 511, 622, 628 and SB 163.

He stated that his concern with HB 361 is that it limits workers benefits, on one part of the body, to 350 weeks rather than an entire lifetime.

He stated that HB 511 is a good bill and he believed it would help correct the problems by providing the information needed in order to make decisions.

He stated that SB 347 is the worst bill in the package because if an employee is seriously hurt on the job, they are fixed and that is the extent of their coverage. These injured employees don't receive benefits for emotional stress or anything that may arise at a later date, due to the accident.

He stated that SB 394 limits attorney fees and should be listed under cost containment. Furthermore, it limits benefits to injured workers, not costs. He urged the committee to vote on this bill separately and not part of the package.

John Alke, Montana Defense Lawyers, stated that his interest deals with the amendment on SB 394. Capping the money insurers can pay their counsel is unreasonable because currently there is no limit for the defense. He asked how workers' compensation will be served after 100 hours of work is performed and the lawyer must stop.

John Malee, Montana Federation of Teachers and State Employees, stated that his organization is opposed to the package on workers' compensation.

Russell Hill, Montana Trial Lawyers, stated that HB 361 provides potential for added costs.

He stated that SB 164 will provide a new risk and burden to employees. He provided the committee with several handouts. **(EXHIBITS # 11, 12, 13, 14, AND 15)**

Dan Shea, self, provided the committee with written testimony. **(EXHIBIT # 16 AND #19).** He stated that the working poor are the majority of the work force and he feels they are not represented in this legislation. He asked where the money comes from for the necessary visits to their physicians. He stated that these employees fall into a catch 22 situation. He referred to the letter he provided the committee and stated that it provides solutions of how to deal with this situation. These people are denied equal protection of the law and can't afford the co-payments. He stated that if the attorney fees are capped, the defense also needs a cap. If this cap does not occur, defense will wait until the attorney is no longer on the case and win the case. Furthermore, the number for this cap seems to be picked out of a hat with no rationale behind it. He stated that if they put a cap on medical, everyone would be out of time.

Lars Erickson, Montana State Council for Carpenters, stated that his organization supports HB's 511, 622, 628 and SB's 163 and 164. He stated that his organization is opposed to HB's 504, 361 and SB 394 and SB 347. He stated that SB 347 is the worst bill in the package.

Bill Egan, Conference of Electrical Workers, stated that his organization doesn't support workers' compensation in the first place because it eliminates due process. He stated that his organization is opposed to HB 504 and HB 361. Furthermore, his organization supports SB 394 if there could be caps on both sides of the fence. They also support SB 347 as amended. He stated that the baby should not be thrown out with the bath water.

Marie Gritzuk, Interdepartmental Coordinating Committee for Women (ICCW), (EXHIBIT #17).

<u>Questions From Committee Members and Responses</u>:

REP. DRISCOLL referred to SB 394 and asked John Alke if $7,500 is the maximum that can be spent to defend against insurance companies? Furthermore, he asked if they could still hire a staff attorney?

John Alke stated that not all workers' compensation claims are with the State Fund.

REP. DRISCOLL asked Mr. Alke if he thinks $7,500 is a good limit?

John Alke stated no.

HOUSE OF REPRESENTATIVES

LABOR COMMITTEE

ROLL CALL DATE 3/16/93

NAME	PRESENT	ABSENT	EXCUSED
REP. TOM NELSON, CHAIRMAN	✓		
REP. GARY FELAND, VICE CHAIRMAN	✓		
REP. STEVE BENEDICT	✓		
REP. VICKI COCCHIARELLA	✓		
REP. JERRY DRISCOLL	✓		
REP. ALVIN ELLIS	✓		
REP. PAT GALVIN	✓		
REP. SONNY HANSON	✓		
REP. NORM MILLS	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL TASH	✓		
REP. ROLPH TUNBY	✓		
REP. CARLEY TUSS	✓		
REP. TIM WHALEN	✓		

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO. SB 347

DATE March 16, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Ann. Jacqueline Lennack	Am. Ins. Assoc.	X w/ amdt	
WAYNE EDSALL	EDSALL Construction	X	
Mike Moiane	MHCA	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO. SB 347

DATE March 16, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Russ Logan	Blgs Chamber	X	
Charles R Brooks	MT Rpt. Ind. Ltsso	—	
Don Judge	MT STATE AFL-CIO		X
DAN EDWARDS	BCBW		X
John Madea	M.E.T. / M.E.S.E.		X
Lori Wright	Mont. PT Assn	—	
Cars Ericson	Carpenters Union		X
Russ Logan	Blgs Chamber	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO SB 347

DATE March 16, 1993 SPONSOR(S) J. Harp

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
George Wood	Mt Self Insurers Assn.	✓	
Dan Shea	A Point of View		✓
Faye Stice	Self	✓	
Pat Twiford	Self Employed	✓	
KIRK HANSON	MT ASSO Injured P.T.'s	✓	
Lee Newman	MT. assoc. indep P.T.'s		
Bob Olsen	MT Hospital Assoc.	✓	
Rich Hill	Gov Office	✓	
Riley Johnson	NFIB	✓	
Don Allen	CWCST	✓	
PAUL SMIETANKA	MONTANA PODIATRIC MEDICAL ASSOCIATION	✓	
TERRY MITTON	CWCST	✓	
Oliver Goe	MMTD MACO MACoTA	✓	
Jamie Doggett	MT Cattlewomen	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

		SUPP.	OPPOSE
HARLee Thompson	MBIA	✓	
LARS ERICSON			X

OCAW
Oil, Chemical & Atomic Workers
International Union, AFL-CIO

International Representative
P.O. Box 21635
Billings, MT 59104

406 / 669-3253 (Home)

HB

SB 347

Testimony of:

Dan C. Edwards, International Representative
Oil, Chemical & Atomic Workers Int'l Union, AFL-CIO
P.O. Box 21635
Billings, MT 59104 669-3253

Testifying before the House Select Committee on Workers' Compensation[1], March 10, 1993, 3:00 p.m., Room 312-3.

****

THE DEAL IS DEAD

If this Bill, and its companion bills HB 604 and HB 504, become law the historic "deal" that brought about workers' compensation programs many decades ago is dead.

Workers' compensation laws are designed to provide an equitable system for handling work related injuries, illness and disabilities, and in so-doing protect the employer from law suits from injured employees. The U.S. Department of Labor describes workers' compensation as follows:

> "Workmen's compensation was devised to assure that benefits would be paid to workers injured on the job, and that they would be paid promptly, with a minimum of legal formality, and without the necessity of fixing the blame for injury. Under laws the cost of work injuries is considered part of the cost of production."

Workers' compensation is a compromise, no-fault, system. It is not, and was not, intended to be totally satisfying to the worker or the employer. The injured worker does not receive his/her full remuneration for loss of wages, but they are entitled to immediate medical care and a percentage of their wages without delay.

---

[1]. Copy of this testimony will also be provided to the members of the full House Labor and Employment Relations Committee.

The devastating attack that this session of the Montana legislature has seen on workers' compensation has only one victim -- the injured worker. This unrelenting attack is truly a case of "blame the victim".

It should be obvious to everyone concerned about Montana's workers' compensation crisis, that at least one of the major reasons for our dilemma is that far too many workers are being injured on-the-job. The State and employers must promote job safety which will result in fewer accidents and ultimately lower job injury insurance premiums. Job safety is good business for the employer as well as for the employee, his/her family, and the community. SB 163 promotes this concept and should be supported.

I would like to highlight some of the major problems with the Bill before you today:

Worker "fees" and premiums: This flies in the face of the entire workers' compensation concept. Immediate medical care at the employer's expense, and paid for by employers, is the major benefit for which workers gave up the right to sue. To ask employees to now pay a portion of the costs for workplace injuries, either through fees or premiums, must not be allowed. Not one of the 50 other states allow such fees, nor does any other state require employees to pay any portion of what is legitimately and morally the employer's workers' compensation premium.

Return to the "company doctor": Despite what some would have you believe, SB 347 returns the workers' compensation program to the days of sending the employee to the "company doctor", whose interest is far more likely to be beholding to the employer who pays his/her salary than to the injured employee. Color it any way you wish, you can not get around the fact that by forcing employees to only go to medical providers with whom the insurance carrier has a "contract", is a return to company doctorism.

Deny secondary medical services to permanently "partially" disabled workers: This provision, which denies secondary medical services to the permanently "partially" disabled unless there is a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment, is simply barbaric. This would "cast out" those injured workers who may need help the most. Who decides what is "cost effective? I'll bet it's not the injured worker!

One concept of SB 347, "managed care" is supported by labor to facilitate lower costs. HB 628 provides managed care in a fair manner and should be resurrected.

Good legislation, as well as good administration, depends on sophisticated cooperation among all parties. The current wholesale attack on the working men and women of this great State, is not the way to "fix" Montana's workers' compensation problems.

In closing, I urge this select committee, and the full House Labor and Employment Relations Committee, to reject the several Bills that totally do away with the original objectives of workers' compensation. Instead, methods that promote workplace safety and reward those employers with good safety and health programs, and other programs which deal with the staggeringly high accident rate in some Montana industries, must be found. Likewise, fair "managed care" should be adopted.

Please give SB 347 a <u>do not pass</u>.

Thank you. I will be glad to answer any questions at the conclusion of the hearing. I would also be pleased to discuss this matter with any Legislator at your convenience.

######

Exhibit 18
3-16-93
SB-347

One concept of SB 347, "managed care" is supported by labor to facilitate lower costs. HB 628 provides managed care in a fair manner and should be resurrected.

Good legislation, as well as good administration, depends on sophisticated cooperation among all parties. The current wholesale attack on the working men and women of this great State, is not the way to "fix" Montana's workers' compensation problems.

In closing, I urge this select committee, and the full House Labor and Employment Relations Committee, to reject the several Bills that totally do away with the original objectives of workers' compensation. Instead, methods that promote workplace safety and reward those employers with good safety and health programs, and other programs which deal with the staggeringly high accident rate in some Montana industries, must be found. Likewise, fair "managed care" should be adopted.

Please give SB 347 a <u>do not pass</u>.

Thank you. I will be glad to answer any questions at the conclusion of the hearing. I would also be pleased to discuss this matter with any Legislator at your convenience.

######

EXHIBIT # 19
DATE 3/11/93
HB SB-347

March 15, 1993
Honorable Marc Racicot
Governor, State of Montana
Capitol Building
Helena, Montana 59601

Re: Senate Bill 347, the Co-Payment provision of the so-called reformed Worker's Compensation Act. Section 7.

Request: That you recommend the co-payment language to be stricken, or at a minimum, that you recommend a means test and a sliding scale so that its impact does not fall primarily on the backs of the working poor.

Dear Governor Racicot:

At a hearing on this bill in the House last week, an agent from your office appeared to urge passage as is. I am sure that you are not personally familiar with the contents of this bill, nor was your agent sufficiently informed to be able to recommend passage as is. Mr. Governor, the co-payment provisions of this bill strike hard and place a heavy load on the backs of the working poor. But before I point out these glaring inequities, let me digress to a letter I gave to your office on February 17, 1993, imploring you to throw the weight of your office behind the laudable errorts by Representative Tuss to increase the minimum wage from $4.24 per to $5.50 per hour. (House Bill 630).

One can only assume you chose not to do so, and no matter what your reasons may have been, I am sure the working poor will never understand or accept them as being justified. In that letter of February 17, 1993 I pointed out to you the pervasivenessness of the working poor situation in this state. In part, I wrote:

> Mr. Governor, you recently declared that you did not want to see a budget balanced on the backs of the state employees. This is all well and good Mr. Governor, but we know a place where all of society balances its books and budgets--They are balanced on the backs of the working poor.
>
> * * * * *
>
> We could go on and on, and on, Mr. Governor. But suffice to say that thousands and thousands and thousands of Montanans comprise that class that wew call the working poor. Please, Mr. Governor, we implore you to give you fulll and unrelenting support to bring the milnimum wages in Montana up to $5.50 per hour.

Needless to say, the bill to increase the minimum wages was not given your support. It went down to defeat in a house committee by a vote of 9 to 7. Nine Republicans voted to kill the bill and seven Democrats voted in favor of the attempt to increase the minimum wage to $5.50 per hour. Perhaps your public support would have made the difference. But whether or not your public support would have made the difference, the fact is now that the working poor are facing at least two more years of earning wages that are no more than subsistence--certainly not a livable wage.

And this brings us to the present co-payment provisions of Senate Bill 347. These provisions will have a profound and negative impact on the working poor, a class which constitutes by far the

largest part of Montana's working force. If all these people quit working on any one day, Montana's economy would come to a complete stop. And it would not start up again until they returned to work.

The co-payment requirements of Senate Bill 347 place yet another burden on the backs of the working poor should they sustain an injury and require treatment by medical providers. Senate Bill 347 requires an injured worker, regardless of means, and regardless of compensation rate, to pay $10 per visit to each provider or 20% of the provider's bill, whichever is less. The Act defines a visit as "each time" a patient sees a "treating physician", "a physical therapist", "a psychologist or hospital outpatient services available in a nonhospital setting."

This means, for example, that each time a patient sees a physical therapist, and this may easily be three to five times a week for an intense and protracted perioid of time (depending on the injury), the patient must pay from his own pocket $10 per visit or 20% of the phyusical therapist's bill for each visit. If for example, the bill is $50 for each treatment (and this is not at all unusual because of the nature of the time devoted by the physical therapist to the patient) the worker must pay $10 as a minimuum of $10 per visit. If the injured worker sees the physical therapist three times a week, the worker must pay $30 dollars per week as the copayment. But if the visits are five times per week, the worker must pay at least $50 dollars per week as his share of the co-payment. In the first case of three visits per month the total cost is $120 per month, in the second case of five vists per month, the total cost is $200 per month.

One of the first questions we must ask is where does the injured worker get the money to make the copayments. The answer in almost all cases will be that he must take this money from his biweekly compensation benefits, which benefits will normally be two-thirds of what the hourly wage was, or at least two-thirds of the average hourly wage. This is a robbing Peter to pay Paul situation. Here the Act provides biweekly compmensation to the worker on the one hand to provide a means of sustenance until the worker can get back to work. But to get back to work the injured worker may need a rather protracted period of intense physical therapy. However, in order to get this physical therapy, the injured worker must dip into his compensation benefits to come up with the money for the required co-payments. If he cannot come up with the money, he cannot get treatment. And if he does not take treatment his compensation benefits can be terminated. This is a classic Catch-22.

The above situation applies to all injured workers, regardless of what their hourly wage is or their average hourly wage. Each of them must pay the same amount, regardless of the amount of biweekly compensation they are receiving. For example, it would, all other things being equal, be much easier for an injured worker to pay the copayments of $120 per month for physical therapy if he was getting a monthly compensation income of $1,000. But what if the injured worker was getting only a a monthly compensation income of $400 per month, such as would be the compensation benefits for the working poor. How could this working poor person live on the $400 per month [illegible] let alone pay back $120 per month in the form of copayments [illegible] therapy treatments? This situati

is fraught with unfairness and discrimination.

At the House committee hearing last week, a restaurant worker from Billings testified that while she was receiving commpensation benefits of a little over $400 per month she was seeing a physical therapist five times a week for treatment of her injuries. How could she ever come up with the required $10 per visit, 5 times per week, 20 times per month==$200? This means that she would have only have $200 per month to live on? At the same hearing I also stressed the inherent unfairness of the copayment provisions and how they discriminated against the working poor by imposing a heavy and indeed impossible burden on them to come up with the required copayments. The Committee voted passage without making any changes in these copayment requirements. Once again the working poor have been victimized by the system.

Also at the hearing last week,the Washington Corporation and Billings Deaconness Hospital endorsed SB 347 in total. But one can well imagine what the biweekly or monthly compensation benefits would be to an injured Washington Construction worker as compared to the benefits paid to a nurses aide at the Billings Deaconness Hospital. Yet, if both had the same injury and required virtually the same kind of treatment in terms of duration and intensity, one injured worker would most likely have the means to make the copayments, but the injured nurses aide would be financially devastated by being compelled to make the copayments as a condition of treatment and perhaps also a condition of full recovery.

These copayment requirements strike hardest at the working poor, compelling those to pay who are least able to pay, and who must pay the same amount as those who may be receiving two, three, or perhaps even four times the amount of biweekly or monthly compensation benefits. The nurses aide at Billings Deaconness Hospital will be compelled, for the same kind of injury, and the same kind of treatment, to pay a much higher percentage of her biweekly or monthly compensation benefits than her counterpart injured worker at Washington Construction. This is not only unfair, it may well be a denial of equal protection of the law.

Though the law on its face does not discriminate because all must make copayments of $10 per visit, or 20% of the cost per visit, whichever is less, in fact this law places an unfair and discriminatory burden on the working poor because it compels them to pay back a higher percentage of their comensation benefits as a condition to obtaining medical provider treatment. The working poor in fact suffer the further consequences of their poverty when they attempt to seek medical provider servides under the Workers' Compensation Act. Call it by any other name--this is discrimination--discrimination against the working poor.

So once again we have seen how government, how society, balances its books, budgets and profits on the backs of the working poor.

In summary, the concept of copayments, not original to Montana, conceivably has a desirable intent, but the concept, as applied here, is fundamentally flawed.

If any system of copayment has merit, it must, under any system of fairness, by means tested and have perhaps a sliding scale of copayments, depending on the biweekly or monthly compensation benefits received by the worker. Section 7 does not contain a means test or a sliding scale.

Second, a copayment in a worker's compensation context, loses any merit that it might have when we realize that the copayments must come from the compensation benefits enacted to sustain the worker at a minimum level during his period of recovery up to the time he returns to work if such be the case. The injured worker needs the compensation benefits to live on and should not be compelled to pay them over to a health service provider as a condition of obtaining medical provider treatment for his injury.

Third, and very important, because the copayment requirements have no means test or sliding scale mechanism based on ability to pay, the copayment requirements discriminate against the working poor, those least able to make the copayments from their compensation benefits, and because they are effectively denied medical provider treatment, they are denied equal protection of the law.

Mr. Governor, I hope you can find it in your heart to recommend that the copayment requirements of Section 7 be stricken from Senate Bill 347. Aside from the reasons given, they inflict simply one more indignity on the working poor of this state.

Sincerely and Respectfully,

Daniel J. Shea

Daniel J. Shea
Helena, Montana

cc. The Appropriate Committee Chairman and Members
The Press

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS---REGARDING---IMPAIRMENT---EVALUATIONS;~~ REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711;~~ AND 39-71-727, AND 39-71-743, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, ~~and all policies--insuring--the payment--of-compensation-under-the-Workers'-Compensation-Act shall~~ must provide that the insured ~~shall--have~~ has full freedom of choice in the selection of any ~~duly~~ licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of ~~his~~ the person's practice. Whenever ~~such~~ the policies insure against the expense of drugs, the insured ~~shall--have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing--in-this-section-shall~~ This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1)~~;--nor-shall-this~~. This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

REFERENCE BILL: INCLUDES GOVERNOR'S AMENDMENTS DATED 4-16-93

Section 2. Section 39-71-116, MCA, is amended to read:

"~~39-71-116.~~ **Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is

a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related

employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

~~(7) "Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is located or a board-certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.~~

~~(7)~~(8)(7) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9)(8) "Department" means the department of labor and industry.

(9) "DISABILITY" MEANS A CONDITION IN WHICH A WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT IS DIMINISHED AS A RESULT OF PHYSICAL RESTRICTIONS RESULTING FROM AN INJURY. THE RESTRICTIONS MAY BE COMBINED WITH FACTORS, SUCH AS THE WORKER'S AGE, EDUCATION, WORK HISTORY, AND OTHER FACTORS THAT AFFECT THE WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT. DISABILITY DOES NOT MEAN A PURELY MEDICAL CONDITION.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by

compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work-related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the

employer ~~shall~~ has not ~~have~~ operated a sufficient or any length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if no average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~(18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~(19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state.

Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(17) The term "physician" includes "surgeon" and in either case means one authorized by law to practice his profession in this state.~~

~~(18)~~(20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment PRESCRIBED BY A TREATING PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability. ~~The term includes medical, surgical, hospital, nursing, and ambulance services and drugs or medicine.~~

~~(19)~~(22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~(23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~(24) "Reasonably safe tools and appliances" are such

tools and appliances as are adapted to and are reasonably safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, ~~physical--restoration,--physical--conditioning,--or-exercise programs~~ PHYSICAL RESTORATION PROGRAMS AND OTHER RESTORATION PROGRAMS DESIGNED TO ADDRESS DISABILITY AND NOT IMPAIRMENT, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the

following must be furnished:

(a) After the happening of ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection--(1)~~(d) this chapter, the insurer shall furnish~~,-without-limitation-as-to length--of-time-or-dollar-amount,~~ reasonable primary medical services ~~by-a--physician--or--surgeon,--reasonable--hospital services-and-medicines-when-needed,-and-such-other-treatment as--may--be--approved--by--the--department--for-the-injuries sustained,-subject-to--the--requirements--of--39-71-727~~ for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

~~(b)~~(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to-rules adopted-by-the-department~~ only if the travel is incurred at

the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

~~(d)~~(e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

(f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition; or

(ii) when necessary to monitor the status of a prosthetic device.

(g) If the worker's treating physician believes that palliative or maintenance care that would otherwise not be compensable under subsection (1)(f) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department

for the treatment. The department shall appoint a panel of physicians, INCLUDING AT LEAST ONE TREATING PHYSICIAN FROM THE AREA OF SPECIALTY IN WHICH THE INJURED WORKER IS BEING TREATED, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) The department shall annually establish a schedule of fees for medical nonhospital services ~~and--hospital outpatient-services-that--are--available--in--a--nonhospital setting--and-that-are~~ necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section ~~14~~ 13].

(3) ~~Beginning-January-1,-1988,-the~~ The department shall

establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates ~~must~~ MAY be based on per diem or diagnostic-related groups. THE RATES ESTABLISHED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION MAY NOT BE LESS THAN MEDICAID REIMBURSEMENT RATES. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities. FOR SERVICES AVAILABLE IN MONTANA, INSURERS ARE NOT REQUIRED TO PAY FACILITIES LOCATED OUTSIDE MONTANA RATES THAT ARE GREATER THAN THOSE ALLOWED FOR SERVICES DELIVERED IN MONTANA.

(4) ~~Notwithstanding--subsection--(2),-beginning-January 1,-1988,-through-December-31,-1991,-the-maximum-fees-payable by-insurers-must-be-limited-to-the-fee-schedule--established in--January--1987.-Notwithstanding-subsection-(3),-beginning January-1,-1988,-through-December--31,--1991,--the--hospital rates--payable--by--insurers-must-be-limited-to-those-set-in January-1988,-After-December-31,-1991,--the~~ The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage as defined in 39-71-116.

(5) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of

this section.

(6) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

(7) (a) After the initial visit, the worker is responsible for 20%, BUT NOT TO EXCEED $10, of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease, UNLESS THE VISIT IS TO A MEDICAL SERVICE PROVIDER IN A MANAGED CARE ORGANIZATION AS REQUESTED BY THE INSURER OR IS A VISIT TO A PREFERRED PROVIDER AS REQUESTED BY THE INSURER.

(b) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsections (7)(a) and (7)(b), means each time the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(D) A WORKER IS NOT RESPONSIBLE FOR THE COST OF A SUBSEQUENT VISIT PURSUANT TO SUBSECTION (7)(A) IF THE VISIT IS AN EXAMINATION REQUESTED BY AN INSURER PURSUANT TO 39-71-605."

~~Section 4. Section 39-71-711, MCA, is amended to read:~~

~~"39-71-711. Impairment evaluation ratings. (1) An impairment rating:~~

~~(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;~~

~~(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and~~

~~(c) must be expressed as a percentage of the whole person.~~

~~(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.~~

~~(3) An evaluator must be a physician licensed under~~

~~Title-37,-chapter--3,--except--if--the--claimant's--treating physician---is--a--chiropractor,--the--evaluator--may--be--a chiropractor-who-is-certified-as-an-evaluator-under--chapter 12.~~

~~(4)~~(3) ~~Disputes-over-impairment-ratings-are-not-subject to-39-71-605.~~"

Section 4. Section 39-71-727, MCA, is amended to read:

"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the-physician-specifies--no--substitutions~~ or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist

shall certify that the ~~physician-specified-no--substitutions or-that-the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section ~~7~~ 6] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care

organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9 8]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable

injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 6.** Preferred provider organizations -- establishment -- limitations. In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with ~~physicians or physician groups or clinics, hospitals, pharmacies, physical therapists,~~ suppliers of soft and durable medical goods, and ~~other~~ medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. THIS SECTION DOES NOT PROHIBIT THE WORKER FROM CHOOSING THE INITIAL TREATING PHYSICIAN UNDER [SECTION 5(1)].

NEW SECTION. **Section 7.** Workers' compensation managed care. (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6 5], through appropriate

health care professionals.

(2) The department shall develop criteria pursuant to [section ~~10~~ 9] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A WORKER WHO IS SUBJECT TO MANAGED CARE MAY CHOOSE FROM MANAGED CARE ORGANIZATIONS IN THE WORKER'S COMMUNITY THAT HAVE A CONTRACT WITH THE INSURER RESPONSIBLE FOR THE WORKER'S MEDICAL SERVICES.

NEW SECTION. **Section 8. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in [section ~~10~~ 9]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 9. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to

provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. WHEN A HEALTH CARE PROVIDER, A GROUP OF MEDICAL SERVICE PROVIDERS, OR AN ENTITY WITH A MANAGED CARE ORGANIZATION IS ESTABLISHING A MANAGED CARE ORGANIZATION AND INDEPENDENT PHYSICAL THERAPY PRACTICES EXIST IN THE COMMUNITY, THE MANAGED CARE ORGANIZATION IS ENCOURAGED TO UTILIZE INDEPENDENT PHYSICAL THERAPISTS AS PART OF THE MANAGED CARE ORGANIZATION IF THE INDEPENDENT PHYSICAL THERAPISTS AGREE TO ABIDE BY ALL THE APPLICABLE REQUIREMENTS FOR A MANAGED CARE ORGANIZATION SET FORTH IN THIS SECTION, IN RULES ESTABLISHED BY THE DEPARTMENT, AND IN THE PROVISIONS OF A MANAGED CARE PLAN FOR WHICH CERTIFICATION IS BEING SOUGHT.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for

the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that

meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review~~,~~ AND service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented

history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner, OR A CHIROPRACTOR.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 10.** **Compliance with medical treatment required -- termination of compensation benefits**

for noncompliance. An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization OR TREATING PHYSICIAN;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 11.** **Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing ~~minimum~~ hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 12.** Physician self-referral prohibition. A UNLESS AUTHORIZED BY THE INSURER, A treating physician may not refer a claimant to a health care facility

~~outside--the--physician's--office--practice~~ at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer OR THE CLAIMANT is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 13.** Medical advisory committees -- composition -- function. (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

(3) THE DEPARTMENT MAY SEEK RECOMMENDATIONS FOR REPRESENTATIVES FROM THE STATE LICENSING BOARDS GOVERNING THE PROVIDERS.

SECTION 14. SECTION 39-71-743, MCA, IS AMENDED TO READ:

"**39-71-743. Assignment or attachment of payments.** (1)

No payments under this chapter shall be assignable, subject to attachment or garnishment, or be held liable in any way for debts, except:

(a) as provided in 71-3-1118; or

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of social and rehabilitation services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act or Occupational Disease Act of Montana, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. No Except as provided in 39-71-704(7), a fee or

charge ~~shall be~~ is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

NEW SECTION. **Section 15.** Codification instruction. [Sections 6 5 through ~~14~~ 13] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 6 5 through ~~14~~ 13].

NEW SECTION. **Section 16.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 17.** Retroactive applicability. Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before

[the effective date of this act].

NEW SECTION. **Section 18.** Effective date. [This act] is effective July 1, 1993.

-End-